

ONE HUNDRED YEARS
OF AMERICAN PSYCHIATRY

ONE HUNDRED YEARS OF
American Psychiatry

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PRESENTING THIS VOLUME

FOREWORDS are written but not read. This one is an exception. The reader is urged to cast more than a casual glance into it, for if he skips over or through it as is the custom the ease and serenity with which this book deserves to be read might be disturbed by queries not easily answered and doubts not easily dispelled. These anticipated doubts and queries might better be attended to in advance.

The table of contents may at first glance suggest that many essential aspects of American psychiatry have failed to find proper or even any representation between these covers. There is no special chapter on juvenile delinquency, for instance, or prison psychiatry, or psychoanalysis, or child guidance, or psychiatric social work, or psychiatric education. There is not even a comprehensive history of the American Psychiatric Association, the one hundredth birthday of which this volume commemorates.

The history of American psychiatry *is* the history of the American Psychiatric Association, and the tradition of this Association permeates all the pages which are herewith submitted to the reader and committed to the forbearance of the psychiatric generation whose spiritual roots are now one American century strong.

This volume is not a symposium on what American psychiatry is doing or trying to do. It is not a list of past achievements; it is not a series of epitaphs on the graves of men, things, and ideas of days gone by; nor is it a chronological history of psychiatry's organizational growth.

So much for the negative description. The volume *is*, or it is intended to be, a historical synthesis of a century of American psychiatric evolution, of the birth and development of a medical specialty which but a short one hundred years ago was nonexistent either in fact or in name, and which now not only has a definite, unmistakable name but endless dynamic ramifications. This specialty touches on every aspect of the psychological and sociological problems which make up our civilized living, healthy and diseased. This volume is therefore intended to represent a survey of psychiatry as a growing cultural force. If we were able to attain our ideal, the volume will be a modest but earnest contribution to the history of American thought and culture as reflected and refracted in the development of a medical discipline which is still young and vigorous and ambitious enough to be adventurous, and yet is already mature enough

to become a factor in almost every walk of our daily life: as human beings, as citizens, as men-in-the-street and as leaders of others, as pupils at the hands of life and as teachers under the guidance of the laws of mental functioning, as prisoners of the law and as judges on the bench.

This ambitious ideal underlay the planning and the fashioning of the volume. Those responsible for bringing the book into being claim nothing more than this ideal aspiration. The authors of the individual chapters were left with their complete freedom of judgment and opinion. Each one of them retained before and during and after the completion of his chapter his own respective trend and even bias. It was not uniformity of opinion but uniformity of perspective which we aspired to. Each individual chapter may or may not stand by itself; it may or may not withstand the critical analysis of the reader. But the book will have to be looked upon and stand as a whole, as a concerted reflection from the mirror of the past beamed on that which psychiatry embraces.

If the reader bears this in mind, he will then be able easily to discover that the above-mentioned apparent omissions are only apparent. All aspects of modern psychiatry will be found in these pages treated in accordance with the cultural, historical perspective and within the frame of reference which a synthesis, not a symposium, imposes upon us.

The reader is also invited to pause and reflect that the book was conceived in 1941, in the midst of a world crisis, to which was soon added the stunning fire and smoke of Pearl Harbor; it was composed and worked over during the darkest war days of 1942, the less dark but sacrificial year of 1943, and the more hopeful but turbulent and not less sacrificial first half of 1944. Such reflection may suggest to the reader yet another motivation which prompted and inspired those who are responsible for this volume: the American Psychiatric Association, its Committee on the History of Psychiatry, the editors, the contributors, the designer, and the printer of the book.

For wars, even the shortest and least bloody and successful wars, add very little to the substance of the life of a nation, but they invariably and ruthlessly subtract something essential from the spiritual life of man. Wars awaken man to self-sacrifice and heroism, but Mars is an even more perfidious bearer of gifts than the Greeks—he impairs our cultural heritage, which in times of martial crises must be saved at any price, and any contribution, no matter how small, to the work of cultural salvage must be made with utmost zeal and care.

The history of a century of psychiatry, like any page of medical history, contains numerous cultural values, and it is hoped that this volume will in some modest and humble degree present a bit of cultural salvage from that heap of rubble where life is fused with death, crippling wounds with heroic power, love with hate, illness with health, and frailty of body with miraculous greatness of mind.

The triple chapter on military psychiatry bears testimony to the expanded scope and practical preparedness of our specialty. When the Union was at war with itself, some of the leading psychiatrists, as pointed out by Dr. Hall in his Introduction, were active medical participants and fell victims in the conflict. But as noted by one of the contributors to this volume, one could search in vain for the smallest reverberation of the Civil War in the meetings of the Association of Medical Superintendents. The century which lies behind us has taught us that psychiatry, while it evolved and grew to become a well-defined specialty, yet cannot be insulated against the impact of cultural crises and history, nor can it isolate itself and avoid the call to arms. It never has avoided it, but the work of history and psychological science had to mature so that psychiatry could develop a sufficiently sensitive hearing and instantly heed the first call with readiness and eagerness. It is this gradually growing social responsiveness that these pages should reflect, and we hope they do.

In this our effort we are grateful to the American Association of the History of Medicine, which through a special Committee on the History of Psychiatry joined hands with the American Psychiatric Association in planning and working on the volume. The members of this Committee are members of the Editorial Board, and each one of them prepared a special study to form a corresponding chapter of the book. It is the first time to my knowledge that two national American medical organizations have joined in a common effort of productive research.

Viewed from the standpoint of cooperative effort and increasing social consciousness, the Centenary Emblem appearing on the title page acquires an added meaning, for the veil of isolation of science from social problems and public issues has lifted in these one hundred years more fully than ever before.

This emblem too is the result of a coöperative effort. One hundred and twenty-four artists thought and worked on the subject and submitted their sketches. Thanks to the generosity and hospitality of the Directors of the Museum of Art of the Rhode Island School of Design, an exhibi-

tion of all sketches submitted was arranged in the Museum, at Providence. Its curator, Miss Miriam A. Banks, gave her time and industry in arranging the exhibition. Paul Manship, the sculptor, Leon Kroll, the painter, and Eric Gugler, the architect, formed the jury which selected the three winning sketches. Their sensitiveness and skill as great artists are common knowledge; their kindness, generosity, and understanding are here gratefully acknowledged. The artists who designed the winning sketches were: first prize, Wheeler Williams of New York; second prize, Wolf Lederer of San Francisco, third prize, Theodore Juraschek of Pittsburgh, Pennsylvania. The sketch which won first prize became the Centenary Emblem of the American Psychiatric Association by vote of the Council.

The production of this volume was helped immeasurably by two generous gifts made by men who wish to remain anonymous. The appreciation of this generosity ought not to remain as anonymous and inconspicuous; it is registered here with the enthusiasm which the cause deserves.

Good fortune was with us when we found that the Columbia University Press, which expressed its readiness to publish the book for us, had the services of Mr. Melvin Loos. It is to Mr. Loos that we owe that which makes the volume an excellent example of bookmaking. Mr. Loos's happy ideas and sense of fitness are reflected in the format, the half-rag paper, which is watermarked with the initials of the American Psychiatric Association, the choice of the Baskerville type, the gravure illustrations, and the binding. To the George Grady Press we owe acknowledgment for the careful and neat job of printing.

The role played by the three most recent past presidents of the Association, Drs. Stevenson, Hall, and Ruggles, is fully brought out in the Introduction.

The coöperation of the members of the Editorial Board has at all times been steady and exemplary. So was the coöperation of Franklin B. Kirkbride, a son of one of the thirteen founders of the Association, who preserved not only many documents of his father—the first Secretary of the Association—but also other data and memorabilia relating to the history of psychiatry in America. Mr. Kirkbride's enthusiastic responsiveness to and understanding of our needs in connection with our work proved most helpful.

The scope of our effort, of the actual details to be attended to, was such that despite all the excellent contributions of those already mentioned, our task could not have been accomplished properly without the unceas-

ing cooperation of countless members of the Association and of various institutions, county clerks, clerks of surrogate courts, and registrars of probate courts who helped the Committee on the History of Psychiatry and the Editorial Board in the work of research. It is to be regretted that it is impossible to mention them all by name here, the impossibility becomes self-evident if we bear in mind that about two thousand individual, not circular, letters were written in connection with the search for data, signatures, portraits, and sundry other bits of information which were needed.

We are indebted to the Division of Manuscripts of the Library of Congress; to Dr. Archibald Malloch, Librarian of the New York Academy of Medicine; to the Medical Society of the State of New York; to the National Committee for Mental Hygiene and its Director, Dr. George S. Stevenson, to the National Museum at Independence Hall, Philadelphia; to Mrs. White for providing us with a portrait of Dr. William A. White; to the State Library of Massachusetts for an excellent portrait of Dr. Charles H. Stedman and his signature; to the Massachusetts Historical Society, to the Connecticut Historical Society; to the Welch Library of Johns Hopkins University for a copy of Sharples' portrait of Benjamin Rush; to Dr. Arthur H. Ruggles for an excellent photograph of the portrait of Isaac Ray which hangs in Butler Hospital; and to Dr. Winfred Overholser for the photograph of Dorothea Dix at St. Elizabeths Hospital.

The vicissitudes of searching for original data and the enthusiasm and loyalty to factual research are well illustrated by the story of how we ultimately succeeded in locating the signature of one of the Original Thirteen, Dr. Samuel White. After months of effort we were on the point of giving up our search and having Dr. White's signature the only one missing in the volume. We had the records of the city of Hudson, New York, carefully searched, without avail—despite the fact that Samuel White was a physician in Hudson and at one time mayor of that city. No trace of any letters, or of a last will, or of any other document bearing Samuel White's signature was found. Dr. Cecil L. Schultz, President of the Columbia County Medical Society, was eager to help but his efforts, like ours, proved of little avail. Apparently inspired with the task and challenged by its toughness, Dr. Schultz went to the old town pharmacy, which had been in the possession of the same family for over a century and a half; but no old prescription or memorandum written by Dr. White could be found in the archives of the pharmacy. We had to give up the search.

Shortly afterward we learned that Mr. Arthur S. Wardle, a descendant of the founder of the drug store and one of the members of the present Wardle Brothers Pharmacy, was sufficiently stimulated by his conversation with Dr. Schultz to recall that a local Hudson doctor, the great-grandson of a physician, must have in his possession the original commission issued to his great-grandfather for the practice of medicine, and that that commission was signed by Dr. Samuel White. The recollection proved correct, and a photograph of the commission, bearing the signatures of Governor De Witt Clinton and Dr. Samuel White, was made and put in the hands of the Associate Editor of this volume.

To Dr. Cecil L. Schultz and Mr. Arthur S. Wardle special acknowledgment is due. Their contribution appears here as but one signature of one man, but more labor was spent and more industry was involved in finding this signature than on many of the others put together, and their contribution has the distinction and the value of having helped us to make a certain part of the volume complete.

As we approach the last lines of this presentation and lead the reader *in medias res* of the volume, one must express the sense of obligation to Mr. Austin Davies and his staff for their untiring help in the endless administrative details connected with the organization of our book. In addition, Mr. Davies from the very outset proved an enthusiastic and always wise counselor in the business of making a living thing out of a project.

The efforts of Miss Valerie Reich, who did most of the necessary typing, including many pages of the chapters after they had been edited, are gratefully acknowledged. Miss Reich's industry and discernment were most helpful and valuable.

The bulk of editorial assistance, proof reading, checking up the data, and correlating the various elements which make up a manuscript, from a footnote to factual historical coherence, fell upon the shoulders of Miss Margaret N. Stone. The Committee on the History of Psychiatry, which originally started the work on this volume, and the Editorial Board owe Miss Stone a debt of gratitude for the work done without stint and with literary and historical imagination.

GREGORY ZILBOORG

New York,
March 15, 1944

INTRODUCTION

WILLIAM HENRY HARRISON, ninth President of the United States, was dead on April 4, 1841, one month after his inauguration. Not one of his eight predecessors had died in office. His successor, John Tyler, the Vice President, was a native, too, of Charles City County in Virginia. Both were college-bred and were members of distinguished families.

Years before, the sudden and unexpected death of Benjamin Harrison, on his plantation "Berkeley" in Charles City County, had called home his son, William Henry Harrison, from Philadelphia where he had gone to continue under Dr. Benjamin Rush the study of medicine he had begun in Richmond. But the state of affairs at home made inadvisable the resumption of his medical studies by the young Virginian, and for a brief period he managed the ancestral plantation. Eventually he yielded to the call to arms, as many another young man in Virginia had done, and as a soldier at one time and as a public official at another he finally became a national figure. Neither before nor since his administration of one brief month has medicine come so near to occupancy of the White House.

When the Thirteen Founding Fathers of the Association of Medical Superintendents of American Institutions for the Insane were in their first assemblage in the Jones Hotel in Philadelphia in October, 1844, John Tyler was within five months of the close of his single presidential term. The citizens of the adolescent Republic, already so spacious that the Federal Government could not adequately police it, called James K. Polk from Tennessee to launch and to carry through a war against Mexico. The single presidential term of Polk embraced that struggle and its successful conclusion, and the hero of that national foray promptly became President. But the old warrior, Zachary Taylor, inured to the hard field of battle, was able to endure the White House for only a little more than a year. Then Millard Fillmore became the second Vice President to become President of the United States. Within a period of less than a decade two Presidents had died in office, each of whom had been hardened by long military service. Are the importunities of the office seeker more deadly than the assaults of the enemy?

By the time the Association of Medical Superintendents had assembled in its third annual session in New York City in 1848, the Mexican War had been brought to a victorious conclusion. In consequence of that na-

tional adventure, the new nation had become geographically larger and richer, and the people were becoming impressed by their own potentialities as individuals and by the military might of their young nation. Is it any wonder that national opinion became somewhat puffed up?

Within half a year after the organizing meeting of the Association in 1844, Andrew Jackson lay dead at the Hermitage. From him, more than from any other individual, his fellow countrymen had absorbed their conception of democracy in its practical applications to their daily lives and to the international relationships of their government. Jackson was without aristocratic background and without formal education, but there is no evidence that he experienced embarrassment in coming to the headship of the national government in immediate succession to John Quincy Adams, who had acquired what was best in education and in culture both in his native country and in long residence beyond the Atlantic.

I find myself constantly recurring to contemplation of the influence exercised by Andrew Jackson during the long and difficult years of the formative period of our government, which did not come into being fully formed, as Pallas Athene sprung forth from the head of mighty Zeus.

Jackson was not highly intellectual; he was passionate and often the victim of his own violence; and his character was not always above reproach. But he was realistic in his attitude toward life; he probably never felt physical fear, and his will was inflexible. His insistence that the government was both the creation and the possession of the people—of all of them without distinction, and not of a mere group of them—and that they could do with their own government and to their own government as they would, constitutes his contribution to history.

Of the six predecessors of Jackson in the presidency two, father and son, came from Massachusetts and four from Virginia. In the long and impressive period in our national life of more than a century since Jackson returned to the Hermitage, only four native Virginians have reached the presidency; and not another native of Massachusetts has occupied the White House since John Quincy Adams experienced the discomfort of moving out to permit Andrew Jackson to move in.

A small oligarchy, almost entirely of New England and of Virginia origin, had brought our unique form of government into being and had dominated it for more than a generation. Andrew Jackson broke their power by placing the government in the care of all the people. He removed the government from the narrow coastal strip and took it out into

the everlasting hills and amongst the towering mountains from which he came. He was a frontiersman, an individualist. He believed that man can do what he wills to do. Jackson transformed into acceptance by the people and into national action the democratic philosophy of Thomas Jefferson, the moving oratory of Patrick Henry, and some of the radical demands of Samuel Adams.

That the attempt to democratize life and government constitutes a continuing adventure we do not always remember; it probably never eventuates in complete success, nor does it ever result in absolute failure. The process demands repeated compromises and countless experiments.

Probably only a few hours before Andrew Jackson went forth on his final adventure, his most distinguished and devoted disciple reached him from far-away Texas, and went down on his knees beside the dying old warrior. Within half a generation Sam Houston had created a Republic and had brought about the annexation to the United States of a great empire. In answer to the consoling words of Houston, the dying warrior and statesman avowed his deep regret that he was guilty of sins, many of them, some of commission and some of omission; but his final self-reproach and sorrow were that he was leaving alive two mortals unfit to live, one of whom he should have shot and the other hanged. Old Hickory thus paid tribute with his last breath to John C. Calhoun and Henry Clay!

It is impossible to think of James Madison or Thomas Jefferson or Buchanan or William McKinley or Calvin Coolidge so expressing himself about a political rival. But the democratic way of life must allow the people to declare themselves and to voice their passions as well as their deep convictions. No other group of citizens of comparable size could be more representative of all the people of our country throughout its existence than the Presidents of the United States. The impressive stuffed shirt has had his place among them as well as the platitudinous rhetorician.

For almost half a century after the war with Mexico, our country lived in peace with other governments. We had made war against our own people, the British, twice, we had fought our French neighbors. Andrew Jackson had routed the Spanish out of Florida. In all her wars the United States had been victorious, and we were constantly driving the Indians out of their own country.

Peace came at last, and with it both the incentive and the opportunity for internal improvements. The people experienced a great awakening and a realization of their resources; with great vigor they went about the

development of the country. In spite of the great achievements of the relatively unlettered Andrew Jackson, and the people's appreciation of him, they were not unmindful of the insistence of Thomas Jefferson that the citizen is potential and effective only in proportion to his mental capacity and his acquired knowledge. Schools were established, colleges and universities were created; increasing provisions were made for training in the sciences, for the acquisition of professional knowledge, and for the development of skill in the arts and crafts.

Highways were opened, railroads were built, steam-driven vessels were placed on lakes and rivers and were sent back and forth across the seas. Cities sprung up almost fully grown, and the newly built factories, filled with humming machinery, were busy in supplying the people with many products that never before had been available to them. With the coming of increased power afforded by the water wheel and the steam engine came an increase in the capacity to do things, and a more abundant life for the majority of the people. There were more leisure and more opportunity for self-improvement. Although there were no public schools and too few private schools to make education possible for the masses, the people were reading more and more. They listened to discussions of public affairs, and many of them experienced self-improvement through participation in literary and debating societies.

The pride of the people in the government fabricated by their own genius was lessened somewhat by the varied interpretations of the Federal Constitution. Inability to submit to a single meaning of some of the provisions of the instrument resulted in the Civil War. Of that tragic conflict two of the immortal Thirteen Founders became victims—Dr. John M. Galt, indirectly, and Dr. Luther V. Bell, with the Union forces.

Much of the intellectual energy of the statesmen of the nation was utilized between 1840 and 1860 in discussing national constitutional issues and especially secession and slavery. But human slavery was incompatible with the spirit of democracy, and the right of a state to secede would have made a powerful Union out of the question. Had it been possible peacefully to put an end to slavery in the South and to decide whether the group of states constituted a confederacy or a union of states, the war would have been avoided and the development of the country would have proceeded much farther than it has.

Few of the sciences occupied places in the college courses offered, and there were not many professional schools. Even as late as 1840 there were

few schools of medicine in the United States. Hospitals were almost unknown; there were no trained nurses; few surgical operations were performed, and many individuals must have gone to their deaths for want of some simple operation. But a civilization still so crude and so unevenly developed as that of the United States at the mid-period of the nineteenth century had produced at least two surgeons of remarkable diagnostic and operative skill. Both Dr. Ephraim McDowell and Dr. James Marion Sims had become surgeons of international eminence.

Audubon, the unique naturalist-artist, actually lived in the wilderness with the birds he portrayed upon canvas in life size and in their true colors. Edgar Allan Poe, associated with Boston, Richmond, New York, and tragically with Baltimore, had developed his pathic genius among our people and had made his name immortal by the solemn and haunting beauty of the melancholy melody of his deathless rhythms. Emerson was a profoundly different representative of the same period, and Walt Whitman was developing his philosophy of boundless personal freedom.

It was a glorious time of well-established national adolescence in the history of our rapidly developing country, but it was a poor time to be in need of nursing and of medical care. And those who were sick in their minds must have been in even greater misfortune than those who were diseased in their bodies. For those sick in mind there were few hospitals, no nurses, too few physicians, almost no diagnostic aids, and little therapy.

Of such a civilization Dr. Woodward and Dr. Stribling were both products and representatives when they communed together in Staunton about the psychiatric predicament of the lusty young nation, at that time richer by far in potentialities than in actualities.* The other eleven physicians who became immortal by participating in the organization of the Association of Medical Superintendents of American Institutions for the Insane were also all native-born Americans, and products of the new nation.

Soon afterward the Founders of our Association were assembled on an October evening in the home of Dr. Kirkbride in Philadelphia. On the following day the organization was perfected; it stood fast—the only national medical body in existence at that time that has withstood the vicissitudes of all the years of the century. The story of the life of the Association, of the lives of those who brought it into being, and some account of its activities, its achievements and its failures, its aspirations

and its frustrations, and its present state of being lies between the covers of this book.

Near the last of March in 1941, I was told by Dr. Arthur H. Ruggles, then Secretary of the Association, that Dr. George H. Stevenson, of London, Ontario, Canada, President of the American Psychiatric Association, had appointed him, Dr. Gregory Zilboorg, and myself on a preliminary committee to confer with the American Association of the History of Medicine. On May 4, 1941, Dr. Zilboorg and I met with Dr. Ruggles in his room at the Jefferson Hotel in Richmond and Dr. Zilboorg was induced to take the chairmanship of the committee, of which Dr. Ruggles was to act as secretary. During the annual meeting of the Association which opened in the Jefferson Hotel under the presidency of Dr. Stevenson on the next day, the President was authorized to appoint a permanent Committee on the History of Psychiatry. Expression was given to the hope and the purpose of taking into consideration the feasibility of planning a centennial meeting of the Association for 1944 to be held in Philadelphia and of formulating a history of American psychiatry and of the American Psychiatric Association. Soon after the meeting of the Association in Richmond, the President appointed to the permanent Committee on the History of Psychiatry: Dr. Gregory Zilboorg, New York, Chairman; Dr. Earl D. Bond, Philadelphia; Dr. C. B. Farrar, Toronto; Dr. C. C. Fry, New Haven; Dr. H. C. Henry, Richmond; and Dr. William C. Menninger, Topeka.

Dr. Zilboorg immediately became active in the cause, and from that moment he has been unwearied in his own labors and in inspiring others. In response to Dr. Zilboorg's invitation, the Committee met at his home in Poundridge, New York, on November 22, 1941. Present there were Dr. H. C. Henry, Dr. C. C. Fry, Dr. Earl D. Bond, Dr. Arthur H. Ruggles, Dr. Zilboorg, Mr. Austin M. Davies, and myself. Dr. C. B. Farrar and Dr. W. C. Menninger were unable to attend the meeting. On that occasion Dr. Zilboorg reviewed his activities as chairman since the meeting of the Association in Richmond in May. He told of the designation of a group from the American Association of the History of Medicine to represent that organization on a joint Editorial Board to collaborate in preparing the history of American psychiatry. That committee consists of Professor Henry E. Sigerist, of Johns Hopkins University; Professor Richard H. Shryock, of the University of Pennsylvania; Mr. Albert Deutsch, of New York; and Dr. Zilboorg. A report of all that had been done and of plans

to carry the work along steadily to its conclusion was made a few weeks later at a meeting of the Council. A progress report was made at the annual meeting of the American Psychiatric Association in Boston in May, 1942.

On the last night of October, 1942, the newly formed Editorial Board and several of the contributors to this volume met at the Institute of the Pennsylvania Hospital in Philadelphia. There were present on that occasion: Professor Shryock, Professor Sigerist, Professor Kluckhohn, Professor Hart, of Toronto, Dr. Bond, Dr. Bunker, of New York, Dr. Whitehorn, Mr. Albert Deutsch, Dr. Farrar, Dr. Hamilton, Dr. Overholser, Dr. Strecker, Dr. Malamud, Dr. Fry, Dr. Thomas V. Moore, Dr. Zilboorg, and myself. Dr. Zilboorg was able to report that the preparation of material for the volume was well under way, and to give assurance that the volume would be ready for distribution at the Centenary Meeting in Philadelphia.

The war with Mexico was disturbing our national life when the Association was in swaddling clothes. The first World War had already involved our Canadian members when the monumental, four-volume account of the *Institutional Care of the Insane in the United States and Canada* came from the press in 1916. Before another year had passed our own country had allied herself with the other allies for the purpose of concluding that struggle. At the inception of the present volume our fellow members in Canada were involved in the greatest war of all time. Within a period of less than a year after President Stevenson had initiated the historic purpose that brings forth the present volume and that will culminate in the Centenary Meeting in Philadelphia in 1944, our own nation became bound with the other democracies of the world in defense of our traditional way of life. The mighty struggle has made more difficult the preparation of the book, but destiny had decreed that *One Hundred Years of American Psychiatry* would make its appearance at the appointed time.

Res ipsa loquitur. Scarcely a phase of our way of life passes unnoticed. The psychiatrist no longer limits his concern to the mentally sick, nor his labors to the incarcerated. Where life is, there the interest of the psychiatrist is busily engaged in efforts to interpret the most varied and complex of all phenomena.

The general reader, and I hope there may be a multitude of them, must bear in mind always that the greater number of the mentally sick are

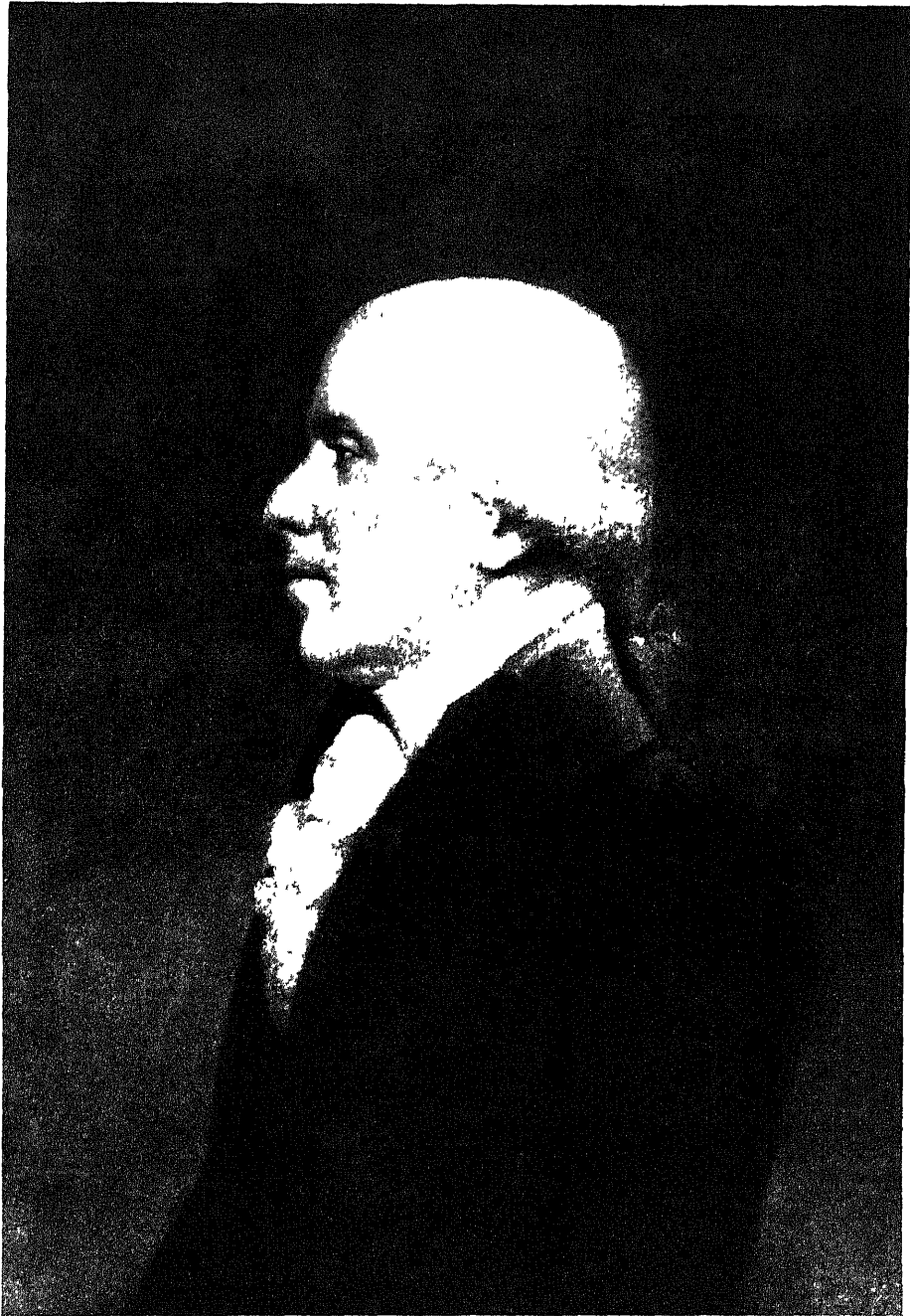
patients in hospitals supported by public treasuries, and that they function under the control of agencies selected by the people. Such hospital constitute, therefore, a rather accurate index of the public conscience. The sick are ministered to as well or as poorly as the people will.

To many we are grateful for contributions of themselves and of their time: To Dr. George H. Stevenson, undeterred by the Dominion's involvement in the great conflict, for initiating the movement; to Dr. Arthur H. Ruggles, whose knowledge of the history of the Association and of its members is unequaled, and to Dr. Gregory Zilboorg, who has slumbered not nor slept since his acceptance of the assignment, and whose polylingual gifts, industry, persistence, knowledge of history, and well-sustained enthusiasm have enabled him to be an inspiring coördinating force. But the book is the portrayal of many phases of American life by the contributing editors. To them we are indebted for the story of the life of a people growing into greatness in a democracy. At the close of the next century our successors will be able to give an account of a more perfect way of life. We pass the torch to them, with keen realization that

We are living, we are dwelling,
In a grand and awful time;
In an age on ages telling,
To be living is sublime.

Richmond, Virginia
March 15, 1944

J. K. HALL



BENJAMIN RUSH

Francis T. Thibling

Samuel B. Woodward

Nehemiah Cutler

Henry Burd.

William M. Auld

Luther V. Bell

Samuel White

Thomas S. Kirkbride

John H. Sealt

A. Brigham

Chas. A. Stearns

Mrs. S. Butler

Isaac Ray

THE SIGNATURES OF THE ORIGINAL THIRTEEN

RICHARD H. SHRYOCK

THE BEGINNINGS: FROM COLONIAL DAYS
TO THE FOUNDATION OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

THE history of the American people is, for the most part, a chapter in the larger story of the modern European peoples. It is true that non-European minorities were incorporated in the American population, and that certain non-European threads were woven into American civilization. It is also obvious that North American geography must have exerted considerable influence upon American life. The exact effects produced by environmental circumstances, notably by contact with "the frontier," is still a matter of disagreement among historians. But there can be no question that the major factors in the history of the United States have been the European peoples and their culture, which first came to these shores in the seventeenth century and have continued to cross the Atlantic in one way or another to the present time.

The most obvious demonstration of this fact is to be found in the similarities between American and Western European culture, which may be observed at any period since the original settlements in this country. Significant changes did occur, as a result of which Americans could be distinguished from Englishmen or Germans even before the Revolution of 1776; but these contrasts were small as compared to the common characteristics. Both the material and immaterial aspects of American culture paralleled, with certain variations, basic developments in European life. Neither the puritanism nor the mercantilism of the eighteenth century, nor the Enlightenment which came later in that century, originated in the English colonies; yet these were dominant features of the American scene. So, likewise, the industrialism and the humanitarianism of the next century were deep undercurrents in European life which reached overseas.

This does not mean that American society merely imitated that of Britain, or France, or Germany. As a colonial folk, Americans naturally borrowed more than they contributed to the sum total of European culture; but from the start, they exerted some influence upon the mother lands. At first, this was largely of an economic character, but before the

close of the eighteenth century, native artists and scientists were working out their own ideas and making a name for themselves abroad in the process. Thus Philadelphia, as the largest American city, was already a world center of the Enlightenment by 1760.¹ Hence one who surveys the historical background of the past one hundred years of American psychiatry—or that of any other art or science—has the difficult task of interpreting social and cultural developments which were basically similar to but never a complete reflection of the older civilization.

Americans, for example, shared in the witchcraft delusions yet never were so completely victimized by this hysteria as were the peoples of France and Germany—historical hullabaloes about Salem to the contrary notwithstanding. In like manner, the establishment of “asylums” for mental cases in the United States, even prior to 1843, was clearly inspired by similar developments abroad; yet this program became more extensive and possibly more significant than the parent movement overseas. It is necessary, therefore, in recalling the similarity of early American and European views of mental disease to note also these occasional contrasts in actual experience.

It is unlikely that the settlers of the English colonies brought with them many who, in terms of contemporary thought, were recognized as mentally abnormal. Those who were obviously “of unsound mind” were presumably left behind during the Atlantic passage. There were few if any references to such individuals in the first records of settlement, save that individual sex-variants occasionally gave trouble and were accorded what was then viewed as summary justice. As time passed, however, local records indicated that colonial villages were beset with much the same types of the mentally ill as had always worried European communities. To the degree that the genesis of mental disease is to be found in either hereditary or cultural factors, this was inevitable; biological inheritance spanned the Atlantic, and the cultural environment set up on this side was, as noted, essentially similar to that on the other.

In so far as puritanism, let us say, was conducive to neuroses or even more serious disorders, it was as likely to generate them in New England as in Old England. Whether the added factors of privation, loneliness,

¹ For an account of medical leadership there, against the background of general cultural achievement, see Carl and Jessica Bridenbaugh, *Rebels and Gentlemen* (New York, Reynal and Hitchcock, 1942).

and danger inherent in frontier isolation increased mental instability, is difficult to say. That frontier conditions may have had this effect at times, however, is as likely as is the opposite assumption so often made; to wit, that these conditions made for hardy vigor and stability. It would be of some interest to compare the concepts and incidence of mental disease obtaining among the English colonists and some of their Indian neighbors; but whatever the anthropologists can tell us about the latter, there are no estimates for colonial morbidity. All one can say is that the haphazard records of village cases—of those “distracted persons” who were at best general nuisances and at worst “quyt madd”—indicate neither a striking lack of mental cases at one extreme nor any great number at the other.

Nor is there evidence of any marked change in mental disease rates during the colonial era. In the petition drawn up by Franklin for the establishment of the Pennsylvania Hospital in 1751, he noted that “the number of Persons distempered in Mind . . . hath greatly increased in this Province,” but he did not attribute this to any growing “nervous tension” or other factor inherent in the times. Rather he ascribed it quite simply to the increase in total population.² As he was a shrewd observer, his implication that the ratio of mental disease had remained unchanged over a considerable period can probably be taken—in the absence of evidence to the contrary—at its face value. Similar though equally negative testimony can be found in Benjamin Rush, who in his various writings on mental disease and on the history of American medicine makes no reference to any increase in disorders of this character. There seems to have been rather a tacit assumption that, like the poor, the “insane” were always with them and in proportionately about the same number.³

Although it may be tentatively assumed that the incidence of mental disease in the colonies was a constant factor, the concepts and methods of treatment employed were clearly variables. It is a truism, but one sometimes overlooked, that different societies have maintained different attitudes toward the sick. Witness the general indifference of the classical world, in contrast to the solicitude expressed by early Christians. With the latter, suffering was even viewed in ascetic terms as a virtue *per se*.

² T. G. Morton and F. Woodbury, *History of the Pennsylvania Hospital* (Philadelphia, Times Printing House, 1895), p. 8.

³ Unfortunately, early American writers on the history of disease, e.g., William Currie (1792) and Noah Webster (1799), give little attention to mental disease, so that indications of its incidence are fragmentary or negative in character.

During the early Middle Ages, the demented as well as the physically ill⁴ seem to have been the beneficiaries of Christian charity, in so far as they were given alms or were taken in by the general hospitals.

Nevertheless, the revolution in world outlook which came in with Christianity was unfavorable to medicine in general and to medical psychology in particular. Theology replaced philosophy, and a confusing blend of religion and magic, the rational empiricism of Greek science. While traces of original observation persisted in general medicine, this was all but obliterated in psychiatry, since certain mental aberrations were peculiarly susceptible to religious interpretations. Those suffering from illusions quite naturally spoke in terms of the prevailing religious beliefs, and claimed powers of prophecy and revelation. As long as they were viewed as having divine inspiration, this tended to raise their status—somewhat as the same types acquired prestige in some recent primitive societies. But even in this case such phenomena were interpreted theologically, and the individuals involved became subject to religious rather than to medical consideration. The doctors surrendered mental patients into the hands of the priests and there they remained, in large degree, until the modern period.⁵ As a result, the Hippocratic view that these diseases were strictly natural phenomena was largely forgotten.

There remained the question of what supernatural influences were involved. These might be lunar or other astrological forces. Or, as noted, the influence might be of divine origin and the inspired one therefore a superior person or even a saint. But the ravings of many persons suggested a more sinister background. Such individuals might be “possessed” of a devil, or in communion with Satan himself. Since Christian theology stressed the freedom of the human will, it was assumed that witches or wizards who had abandoned themselves to these evil contacts had done so of their own consent and were therefore deserving of the most severe punishment. As a lay medical profession emerged again, its members at first accepted these views, and made no demand upon the clergy for the return of this class of patients to medical consideration. Nor did the judges, to whom church authorities referred witches for trial and execution, question the wickedness of those who were condemned.

This is not to say that the majority of the mentally ill were accused of

⁴ This distinction is used in the ordinary sense, without imputing to it any final validity.

⁵ Gregory Zilboorg, *A History of Medical Psychology* (New York, W. W. Norton, 1941), pp. 127 ff

witchcraft, or that all those condemned were necessarily deranged. But the demonological view of mental aberrations was significant for two reasons. In the first place, periods of witchcraft hysteria did ensue when tens of thousands of the mentally ill were tortured and executed—notably during the very post-Reformation era when the American colonies were being settled. In the second place, the theological view stressed the wickedness of witches and thus contributed to the feeling that the mentally ill were dangerous or inferior individuals, set apart from the rest of mankind and not entitled to the mercies otherwise associated with the Christian tradition. This led to brutal treatment, which prompted animal-like reactions, which in turn further confirmed the original assumption about the inferiority of the victims. The vicious circle was no doubt strengthened by a smug consciousness, among “normal” persons, of their own distinct and absolute superiority. Such feelings colored the attitudes of the majority, long after the belief in witchcraft had been abandoned.

Just why the American colonists, believing implicitly in witchcraft, so rarely found it necessary to root it out is not easy to explain. Perhaps, in thinly settled areas, there was less danger of an epidemic spread of witch hunting than was true in more compact communities abroad. Perhaps, too, the colonists benefited by the early development of religious divisions, and by their consequent freedom from unified clerical control. It is no doubt significant that the one serious outbreak of this delusion—that at Salem in 1691–1692—occurred in New England, the only section of the English colonies in which one established church dominated community life. The clergy of this Congregational (“Puritan”) Church were active leaders in the persecutions, just as certain Catholic clergy had been upon the Continent, after all, this “invisible world” of witchcraft was their province. In fairness to the Salem clergy, it must be remembered that they sincerely believed it their duty to rid the town of a terrible menace. So far as proverbial good intentions were concerned, this persecution—like the more ghastly European outbreaks—may be viewed as an early anticrime drive, or even as an attempt to protect the public health through an intensive resort to theological prophylaxis.

In reference to the theology involved, it is of some interest that the development of Calvinist predestinarianism does not seem to have inhibited demonology. One might have expected that the denial of human freedom would have absolved witches of responsibility and would also

have relieved ordinary criminals of the same burden. Neither the Calvinist churches nor the courts under their influence, however, seem to have drawn this conclusion. Indeed the courts of all countries continued to cling to the concept of freedom of will as justifying punishment, until that recent period when its limitations came to be stated in psychological rather than in theological terms. In any case, so far as New England was concerned, it should also be recalled that the dominant theologians there were not strict Calvinists, and that they left some openings in their thought for the concept of free will.⁶ Hence they were not clearly inconsistent in their demand for the punishment of witches, either as a matter of public protection or of vengeance.

To the present reader, the testimony taken at the Salem trials is replete with evidences of hysteria and other disorders, as well as with indications that the so-called witches were thoroughly familiar with all the lore of the tradition. In other words, their behavior resulted from various mental conditions operating in terms of a particular cultural milieu. They solemnly testified as to the use of broomsticks and black cats and all the other occult paraphernalia now relegated to Hallowe'en cards.⁷ What more convincing evidence could have been desired than their own confessions? In that one year of 1691-1692, 250 persons were tried for witchcraft in a town that could hardly have boasted four thousand souls. Fifty were subsequently condemned, nineteen were executed, two expired in prison, and one died of torture.⁸ But note that the hysteria subsided quickly when various prominent folk were accused; and, what is more significant, that it was never revived there or elsewhere in America. Some courageous observers doubted it from the start; and certain of the leaders, notably Judge Sewall, lived to recant their views and regret publicly their participation. Yet the execution of witches continued in Europe, at a declining rate, through the first quarter of the next century, and sporadic instances occurred until as late as the closing years of that century.

Meanwhile, the ordinary treatment of the mentally ill in the colonies

⁶ Perry Miller, *The New England Mind* (New York, Macmillan, 1939), pp. 103 ff.

⁷ Convenient excerpts from the court records will be found in A. B. Hart (ed.), *American History Told by Contemporaries* (New York, Macmillan, 1928), II, 35 ff. For the literature on witchcraft in the Colonies, see "Literature of Witchcraft in New England," *Am. Antiq. Soc. Proceed.*, n. s. X (Worcester, 1895), 351 ff.; G. F. Black, "List of Works in the New York Public Library Relating to Witchcraft in the U. S.," *N. Y. Pub. Lib. Bull.* (1908), XII, 658 ff.

⁸ Albert Deutsch, *The Mentally Ill in America* (New York, Doubleday, Doran, 1937), p. 35

naturally reflected that in the mother country. The Reformation had resulted, in England, in the closing of many small ecclesiastical institutions which had provided asylum for the sick and poor of all sorts. The whole problem of relief was consequently shifted from Church to State or to private philanthropy. Two major developments ensued; first, private patrons took over and revived the larger of the old hospitals—like “Bart’s” in London—and so established a pattern which was followed in building the first hospitals in this country after 1750.⁹ Second, the English Government gradually assumed responsibility for ordinary relief throughout the country and, in the Elizabethan poor laws, made the local community directly responsible. Mild mental patients continued to remain at home or to wander at large, or—if without family support—were taken in by the almshouses. The violent were flogged, placed in stocks, locked up at home, or deposited in the local jail. This was logical enough as long as they were not viewed as requiring medical attention, and since the community’s most immediate problem was one of self-protection.

American villages were usually too small to provide almshouses or even jails, but it was assumed that local authorities were responsible for poor relief, including that of the “insane.” The violent were confined at home, not only for protection but also because mental illness was keenly felt as a family disgrace. Poor relief was involved when a family felt unable to care for a sick individual, and then small funds were grudgingly extended. Thus, in 1699, the town of Braintree, Massachusetts, ordered the Selectman “to treat with Josiah Owen about Ebenezer Owens distracted daughter and given him Twenty pounds money provided he gives bond under his hand to clear the Town for ever of saide girle.” In those instances in which demented persons wandered off from their homes, considerable concern was manifested by towns lest such outsiders become a local burden. The victims were “warned out” of towns much as tramps are today, and they might even be kidnaped by the authorities of one place in order to be abandoned in the next.¹⁰

⁹ Meanwhile, in Catholic Europe also, the State tended to take over Church endowments; but instead of leaving the hospital field to private charity, it allocated this to government institutions. A few hospitals, as is well known, were primarily devoted to the confinement of mental patients. See Albert Babeau, *Le Village sous l'ancien régime* (Paris, Didier et Cie, 1884), pp 321 ff.

¹⁰ Deutsch, *The Mentally Ill in America*, pp 41 ff., H. M. Hurd, et al., *Institutional Care of the Insane in the United States and Canada* (Baltimore, Johns Hopkins Press, 1916), I, 81 ff.

When a colonial town attained a population of several thousand, it followed the English procedure of building a jail and almshouse. Some mental cases were then placed in these institutions, instead of being provided with "outdoor relief." The almshouse was really both a "work house" and a penal institution, and in addition—through its infirmary—a primitive hospital. Such an almshouse was established in Philadelphia in 1732, and in New York City in 1736. It is hardly necessary to add, however, that no special provisions were made, in either the jails or almshouses, for the care of mentally affected inmates.

Meanwhile, as the towns grew, so grew a need for hospitals in the modern sense. In America, as in England, the Protestant churches displayed little concern in the matter. Hence, while in French Quebec Catholic orders provided hospitals during the seventeenth century, nothing comparable appeared in the English colonies until the middle of the eighteenth century. Finally, in 1752, the Pennsylvania Hospital was established by private subscription in Philadelphia as the first institution in the English colonies to care exclusively for the sick. State aid was secured, but the establishment was in no way a state institution.¹¹ The same was true, some two decades later, when Dr. Samuel Bard instigated the building of the New York Hospital.¹²

Notable, in the case of the Pennsylvania Hospital, was the provision for mental patients. Even the assumption that these should receive medical attention was expressed in the original act of the Assembly granting financial aid to the undertaking. Observe that this recognition came within sixty years of the Salem hysteria, when the authorities had expressed an essentially medieval, theological attitude. Obviously the more modern view could not have appeared all at one time or in the mind of any one observer. The need for reviving the classical, medical approach to mental illness had been increasingly asserted by European physicians from the sixteenth to the eighteenth centuries and was percolating into the consciousness of laymen by 1750. It is true that pioneer psychiatrists like Vives and Weyer did not deny orthodox Christian theology in principle, and exerted little influence over their own era.¹³ But times were changing, even as the witches were consumed. The seventeenth century

¹¹ Morton and Woodbury, *History of the Pennsylvania Hospital*, pp. 5 ff

¹² J. B. Langstaff, *Dr. Bard of Hyde Park* (New York, E. P. Dutton, 1942), pp. 35 ff

¹³ Zilboorg, *History of Medical Psychology*, pp. 180 ff

witnessed the advent of a new "experimental philosophy," and by the eighteenth century the physical sciences were making such advances as to undermine theology on the one hand and to open up vistas of progress on the other. This created a new spirit of optimism: Science would go on to bigger and better things. Physicians shared in this optimism and, profiting both by their renewed knowledge of classical medicine and by the growing prestige of their profession, asserted more and more their right to treat mental as well as other types of disease. Hence the view implicit in the act of the Pennsylvania Assembly of 1751.

While this assertion by physicians was fundamentally sound and was a basis for all future progress in psychiatry, the state of medical science in the eighteenth century was such as to involve certain difficulties for actual research or treatments in the mental field. On the negative side, physicians almost abandoned psychology to the philosophers for a time, so that during the seventeenth and early eighteenth centuries most of the writing in this field was associated with general systems of thought rather than with psychiatry.¹⁴ This meant that philosophers were apt to consider even mental diseases as falling within their province—a view not without its limitations. The second systematic study on mental disorders to appear in the United States, as late as 1840, was the work of a clerical philosopher.¹⁵

On the positive side, the story was more complicated. The anatomical research of the Renaissance had led naturally into a study of pathology, which in turn provided a much-needed clue to disease identifications and classifications. Before 1700 Sydenham and others had stressed identification by symptoms, but this had "gone haywire" in the next century in the endless nosologies which were largely lists of names. Morgagni and his contemporaries now showed, after 1750, that by correlating clinical observations with post-mortem findings, vague clinical pictures could be broken down into more specific disease concepts. Thus "inflammation of the chest" could be resolved into such "entities" as pneumonia, bronchitis, pleurisy, and so on. In consequence, pathologists began to revolt against ancient humoral or tension theories and to focus on the localization of disease. The great Paris school of clinician-pathologists subsequently carried Morgagni's lead further, and by 1830 they had definitely

¹⁴ *Ibid.*, p. 265

¹⁵ See below, pp. 25-26

established modern medical science on the basis of a localized pathology.¹⁶

Nevertheless, as noted, certain limitations in this approach were unfortunate for psychiatry. It should be recalled that prior to the dominance of a local pathology, physicians studying mental disease employed both a somatic and a psychological approach. So far as physical causes went, they recognized the role of somatic diseases and of hereditary influences. In so far as the idea of a "hereditary taint" was stressed, incidentally, it furthered the common disdain for the mentally ill. For physical treatments, doctors imposed upon helpless "lunatics" extreme forms of the bleeding, purging, and repulsive remedies then in vogue. In the psychological field, they employed the distinction between reason, feeling, and will and, transcending the older view that all derangements were in the first-named category, recognized disorders in the emotions and in the volitional "faculties." Emotional as well as physical causes were considered. These men's notions as to the way in which love, grief, or fear led to "mania" may now seem naïve, just as their theories of physical causes were frequently oversimplified; but at least these views involved psychological as well as somatic considerations.

When general medicine moved in the direction of a local pathology, however, the difficulties of psychiatry seemed to increase. As the ancient humoral pathology was gradually abandoned, so was classical theory about the association of mental disease with bile and the abdominal organs. It was now generally assumed that the brain was the seat of mental processes,¹⁷ but little progress was made in finding cerebral lesions associated with particular mental symptoms. Moreover, even the clinical side of the physical approach to mental disease failed to make the sort of progress achieved with somatic conditions. Mental symptoms seemed more confusing than physical. Hence, while much was achieved in more accurate pictures of somatic disorders, eighteenth-century physicians wandered in a maze of obscure mental phenomena.

True, they observed much concerning illusions, depressions, "hysteria," and so on, that can now be fitted into modern interpretations. But their classifications, based sometimes on supposed causes and sometimes on symptoms, were confusion worse confounded. Such categories as "amenomania," "manicula," and "manalgia" now require consider-

¹⁶ Richard H. Shryock, *The Development of Modern Medicine* (Philadelphia, University of Pennsylvania Press, 1936), pp. 63 ff., pp. 149 ff.

¹⁷ For criticisms of this dominant, modern view, see Gregory Zilboorg, *Mind, Medicine, and Man* (New York, Harcourt, Brace, 1943), pp. 39 ff.

able deciphering and could hardly have made for clarity at the time. French clinicians, notably Esquirol, brought some order out of this chaos by 1840; yet even their classifications were vague and approximate. Lacking the successful check imposed upon somatic pictures by pathological findings, psychiatric classifications continued to proliferate in the early nineteenth century, much as they had in somatic medicine during the preceding era. As late as 1825-1850, the symptomatic, psychiatric nosologies listed as many as three hundred supposed mental diseases.¹⁸ In other words, American psychiatrists during the first half of the nineteenth century had to labor as best they could without any clear picture as to the identity, to say nothing of the causes, of the conditions confronting them.

Meantime, while psychiatrists were securing little benefit from pathology, the growing emphasis upon local lesions actually handicapped them by discouraging interest in psychological causes and treatments. Indeed, not only did the growing stress upon localization preclude studies of personality—that is, of social and psychological factors—but it even tended to lose sight of over-all physical phenomena. It also happened that prior to about 1830, pathological research had long failed to solve the problem of certain obscure symptomatic conditions, notably of “the fevers.” Lesions either were not found or appeared in many places. This was so confusing that many physicians fell back on the continued use of Greek theories about a generalized pathology of humors or tensions. Thus Cullen of Edinburgh, in the late eighteenth century, stressed nervous tension as a general condition of disease, and his student Benjamin Rush proclaimed a similar view in Philadelphia about 1790, in terms of “excessive action” in the blood vessels.

Now it happened that Rush, who was a child of the Enlightenment, was in the forefront of American physicians in according attention to mental disease.¹⁹ He denied that there could be “ideal diseases”—that

¹⁸ Gardner Murphy, *Historical Introduction to Modern Psychology* (New York, Harcourt, Brace, 1932), p. 135.

¹⁹ His *Medical Inquiries and Observations upon the Diseases of the Mind* (Philadelphia, Grigg, 1812) was not only the first systematic treatise published in the United States but it remained the only one for several decades. The extent of its influence is indicated by the appearance of further American editions in 1818, 1827, 1830, and 1835, and by a German edition in 1825. However, claims (as in Goodman, *Benjamin Rush*, Philadelphia, University of Pennsylvania Press, 1934, pp. 259, 271) that this preceded any important European work in the field, or that it was the only comprehensive American study for over seventy years, are unfounded. The next systematic American work actually appeared just twenty-eight years later. See below, pp. 25-26. See also Dr. Bunker's chapter in this volume, “American Psychiatric Literature during the Past One Hundred Years.”

is, diseases primarily in "the mind"—and, like most of his contemporaries, ascribed the "proximate cause" (pathology) of mental disorders to localization in the brain. But then, in order to bring mental disorders within his theoretical system, he assumed that the brain was involved—either by bodily or by mental causes—through a hypertension in the walls of its arteries. This led him in turn to prescribe physical remedies, and the very remedies he used for all other conditions—primarily bleeding and purging. Anyone could see that if the bleeding continued long enough, "excessive action" in the patient declined! This was hardly a notable contribution to psychiatry.

Rush's theoretical pathology, moreover, exerted an unfortunate influence on the general medicine of his period, as it discouraged the research then so necessary to medical progress. Since he was sure that all disease was a state of the arteries, no further pathological investigations were needed. Hence Philadelphia and other American centers, deeply influenced by Rush, failed to follow Morgagni's lead and by 1820 found themselves hopelessly behind Paris.²⁰ This meant, among other things, that American research failed to keep up with French and German work in neurology as well as in other medical fields, so that after 1820 American psychiatrists looked for inspiration largely to Paris and other European centers.

Before proceeding to this later story, however, it were well to glance at Rush's opinions, not only because these exerted widespread influence in this country, but also because they were largely typical of the psychiatry of the period. Since the localized pathology was not yet dominant in his day, Rush reflected the older interest in personality—in psychological as well as physical factors. His theoretical pathology, to be sure, was entirely somatic, but his etiology rather stressed the mental influences. He recognized such causes as somatic diseases, mental and physical shocks, emotional disturbances, and so on. Sex was assigned a serious role, in terms of either undue restraint or undue indulgence. Onanism alone could produce the most alarming consequences.²¹ Assuming the prevailing faculty psychology,²² he used its terms in distinguishing types of disease, but with little relation to etiology.

²⁰ There were, of course, other factors which delayed pathological research in America. R. H. Shryock, "Factors Affecting Medical Research in the United States, 1800-1900," *Chicago Soc. of Med. Hist., Bull.* (1943).

²¹ *Medical Inquiries and Observations upon the Diseases of the Mind* (4th ed., Philadelphia, Grigg, 1830), p. 345.

²² J. W. Fay, *American Psychology before William James* (New Brunswick, N. J., Rutgers University Press, 1939), pp. 70 ff.

Rush's treatments were of both a physical and a psychological nature. The former, like venesection, related primarily to his tension pathology but also included trial-and-error devices. Thus his use of suddenly alternated hot and cold baths suggests more recent forms of shock treatment. Drugs should be used with some caution. Within the psychological realm, he advocated a sort of moral suasion—patients should have pleasant companions—and even occupational therapy. Most interesting was his scheme for having the patient record his own recollections and experiences, which has been interpreted as an anticipation of analogous procedures in psychoanalysis.²⁸ But he seems to have employed psychological measures for empirical rather than rational reasons, and also at times as a matter of kindness rather than of medical theory. For Rush not only expressed the medical interests of his day, but also the prevailing humanitarianism. Here was a second great influence, comparable to that of medical science itself, which was to contribute to a revolution in the treatment of the mentally ill.

Nearly every social-reform movement of the modern era originated in the eighteenth century: the temperance, anti-slavery, feminist, and various other drives for the better treatment of handicapped or suffering classes had their roots in this period. One factor in these movements was the aforesaid optimism born of scientific progress. Christian tradition, while it encouraged individual charities, had often been pessimistic about long-run social improvements in this world. In contrast, the success of the sciences in actually changing age-old conditions, as in speeding up transportation or in checking smallpox, promoted a view that social betterment could be permanently achieved. But before there could be any desire to secure such betterment in the case of handicapped classes, sympathy for these people had also to be engendered. Science promised a means, but the motivation to employ such means had to be born of humane feeling.

Any comparison of public reactions to human suffering, as these revealed themselves in the seventeenth and eighteenth centuries, shows an increasing sensitivity in the latter era. To take an obvious illustration, the "best people" of 1650 saw nothing objectionable in witnessing the beating of men and women at the cart's tail around town. By 1800, leaders of the same type viewed such procedures as brutal to the victims and degrading to the observers. Just why this increasingly humane temper appeared after 1750 is not easy to explain. One can only suggest hypoth-

²⁸ Goodman, *Benjamin Rush*, p. 265

eses: for example, that rising standards of living among the middle class secured them greater comforts and security, from which vantage points they were shocked when their attention was called to suffering on the levels they had long since transcended. It is also true that improved means of travel and increasing cheapness of printing facilitated social investigations and propaganda, once a reform movement was born.²⁴ A woman who would have been merely a local lady bountiful in earlier days could now become a full-fledged reformer on a national scale.

In certain instances, conditions in the eighteenth century seem to have been worse than in the medieval period, as may be seen in the neglect of poor patients in the larger hospitals of France and England. It has been claimed, again, that drunkenness was at that time more serious in Britain than in earlier days, because of the introduction of gin. In such cases, the reform movements may be interpreted as protests against actual decadence. But usually the emphasis upon brutal conditions was more the measure of a changed conscience than of increasing evils. In the case of the insane, for example, these poor people had long been neglected or abused before the prophets of a new humanity discovered their plight. John Howard was shocked by the treatment of both the sane and the insane in hospitals and jails, and his many journeys through England and the Continent did much to arouse demands for improvement during the late eighteenth century.

In no country was the blend of humanitarianism and of scientific optimism, which we know as the Enlightenment, more obvious than in late eighteenth-century France. Here the aspirations of the philosophers were translated into action in the days of the Revolution. Paris became a veritable ferment of social and political experiment, as well as a center of the sciences. It happened that small private asylums were set up in the city for well-to-do mental patients who could afford the luxury of individual attention, and in these there was opportunity, if the director was so inclined, to provide kinder treatment. It was in such an institution that Philippe Pinel, the great French advocate of "moral treatment" of the mentally ill, had his first opportunity to study psychiatric problems. He soon found that humane inclinations were a valuable supplement to his scientific interests. It appeared that the brutal treatment accorded the more "active" cases, far from checking their ravings, actually promoted them. Kindness, on the other hand, not only met

²⁴ See Maurice Parmelee, *Poverty and Social Progress* (New York, Macmillan, 1916), pp. 233 ff.

the demands of the new social conscience but led immediately to better results. Thus humanitarianism contributed to therapeutic procedures—that is, to science—just as science at times was able to enlighten humanitarianism.

In 1792, the revolutionary government placed Pinel in charge of the Bicêtre, the large Paris hospital housing insane men, and here he was able to apply his “moral treatment” in an extensive and dramatic manner. His success in “striking off the chains” in this institution, and later at the Salpêtrière hospital for women, combined with the fame of his psychiatric writings, did much to arouse interest in “moral treatment” throughout the western world. In England, a similar role was played by William Tuke in founding and administering the York Retreat. Tuke represented the Friends or Quakers, who had for a century been leaders in humane activities of all sorts. But it is notable that this famous Retreat was set up in the very year that Pinel took over at the Bicêtre. Even before this, Vincenzo Chiarugi had inaugurated similar reforms in Florence.²⁸ Such developments were also “in the air” at this time at Philadelphia, where Rush was protesting against conditions in the Pennsylvania Hospital.

This does not mean that even the more enlightened physicians of 1800 advocated a complete abandonment of all physical restraints. As a matter of fact, American psychiatrists long insisted on a degree of physical suppression which was renounced by British leaders. Rush himself set the tone here, since some of his devices like the “tranquilizer” chair seem relatively brutal from a modern perspective. And when any possible conflict arose between Rush the physician and Rush the humanitarian, the former was dominant. Thus his theory about morbid excitement of vessels in the brain indicated various expedients—such as the use of a whirling “gyrator,” or forcing patients to stand erect for twenty-four hours at a time²⁹—which could hardly have been viewed as soothing treatments. Yet he denounced the cold cells, the whips and chains of the old régime, and the tone of his writings was a relatively humane one.

This was fortunate, since Rush’s work was the only American guide available when the first institutions devoted entirely to mental cases were established in this country. About fifteen years after the founding of

²⁸ Arturo Castiglioni, *A History of Medicine*, trans and ed by E B Krumbhaar (New York, Knopf, 1941), p. 633.

²⁹ Rush, *On the Diseases of the Mind*, pp. 179, 190.

the Pennsylvania Hospital, the Virginia Assembly was requested to provide a state institution for "Ideots, Lunatics, and other persons of unsound Minds." The need for both cures and confinement was indicated. When the hospital was established at Williamsburg in 1773, the humane movement was not yet in evidence and the old reliance on chains undoubtedly prevailed.²⁷ The idea of providing a separate institution for this purpose was, of course, not original in Virginia. Large institutions like old "Bedlam" in London and the city hospitals of the Continent had long existed; Bedlam was established in the thirteenth century. But the Williamsburg establishment was notable as the first in this country, and it provided a set-up susceptible to more humane influences, once these were set in motion.

It is worth noting, too, that the principle of state aid was here involved, as the major "insane asylums" built in this country after 1825 were to be state institutions. The appeal for public support doubtless seemed logical in view of the prevailing government responsibility for poor relief, since a custodial asylum was likely to care largely for the poor. It was for this reason that, by 1840, most general hospitals in the United States represented private philanthropies, but that alongside them had evolved state "insane asylums" as well as municipal hospitals, both of which had evolved from the almshouse tradition.

It is true that the Virginia example of state support was not immediately followed. The next "asylums" constructed in the United States either arose in a move to segregate the mental patients of early private hospitals—as in the cases of the New York Lunatic Asylum (1808) and the McLean Asylum of Boston (1818)—or grew out of direct private philanthropies such as the Friends' Asylum at Frankford (Philadelphia, 1817) and the Hartford Retreat (1824).²⁸ The Frankford Asylum and Bloomingdale (which evolved in 1821 from the New York Hospital) were indeed the first distinct mental hospitals to respond to the appeal for "moral treatment." This was again partly due to the influence of the Friends and to the example of York Retreat in England. At Bloom-

²⁷ Wyndham B. Blanton, *Medicine in Virginia in the Eighteenth Century* (Richmond, Garrett and Massie, 1931), pp. 291 ff.

²⁸ On the development of American asylums before 1843, see H. M. Hurd, *et al.*, *Institutional Care of the Insane in the United States and Canada*, and Daniel Hack Tuke, *The Insane in the United States and Canada* (London, 1885). Excellent recent accounts are available in Deutsch, *The Mentally Ill in America*, pp. 132 ff., and in Helen E. Marshall, *Dorothea Dix: Forgotten Samaritan* (Chapel Hill, N. C., Univ. of North Carolina Press, 1937), pp. 69 ff.

ingdale a Quaker merchant, Thomas Eddy, cited the works of Rush, Tuke, and others in holding that the "utility of confining ourselves almost exclusively to a course of moral treatment is plain and simple, and incalculably interesting to the cause of humanity. . . ."

These early philanthropic institutions undoubtedly served, as private organizations have often done, to provide free experiment at a time when state establishments were either nonexistent or too regimented for this purpose. But the limitations of laissez faire philanthropy were also apparent. Quaker leadership was not available in most communities and, as already noted, the other Protestant churches displayed little concern with hospitals of any sort prior to about 1850. Long before that date, it was obvious that any systematic provision for mental patients must come from government sources.

In consequence, the pioneer period of private hospitals (1800-1825) was followed in the thirties and forties by an era of state mental hospitals, in other words, by a return to the governmental support inaugurated in Virginia. Unfortunately, however, in most states local authorities were at first required to support their own cases in the state hospitals; as a result, they were encouraged to keep patients at home under inferior conditions.

The manner in which one state "asylum" after another was established after 1820 was due to continued developments in the two basic influences already noted: namely, science—in this case psychiatry—and the rising tide of humanitarianism. A distinct impetus was afforded, first, by a growing belief among physicians as to the curability of mental conditions. In opposition to the tradition that mental cases never recovered, Rush and his contemporaries had cited many cures. They pointed out that, whatever had been true in the past, "moral treatment" combined with proper medical care could bring results. It required some time for such optimism to "sink in" with either the public or the medical profession; but the apparent success of several private institutions between 1810 and 1830 encouraged this viewpoint.

Outstanding, though typical, was the influence of the Hartford Retreat. Within four years of establishment, its report for 1828 made the remarkable announcement that about ninety per cent of the patients admitted that year had been cured. This statement was picked up and

²⁰ Thomas Eddy, *Hints for Introducing an Improved Mode of Treating the Insane* (New York, 1815), p. 4, cited in Deutsch, *The Mentally Ill in America*, p. 99.

widely circulated in one of the ubiquitous English travel books on America, and did much to promote an optimism which was as misleading as the preceding pessimism.

In attempting to explain this gross exaggeration, it should be remembered that the early nineteenth century had witnessed considerable optimism with regard to the conquest of disease in general. In 1800, as later in 1900, medicine almost promised the millenium. Were not the historic scourges—plague, leprosy, smallpox—either dying out or coming under control?⁸⁰ By about 1840, such views were checked by bitter experience with cholera epidemics and by the nihilism inherent in French research. But meanwhile, it may be that the psychiatrists of 1830 still labored in the after-glow of the earlier enthusiasms. They were also tempted to claim as much as possible for moral treatments in order to secure public support of much-needed hospitals. This was a “commercial age” and governments were more likely to build institutions if they could be persuaded of promising results. Moreover, although quantitative procedures—case records and clinical statistics—were now being advocated by the French school, these could not yet be used with any reliability in psychiatry. The Hartford Retreat may have admitted cases not primarily mental in nature, and—what is more likely—discharged some patients who were not really cured. The statistics were also selected and interpreted in such a way as to leave the best possible impressions.⁸¹

In most instances during this period physicians were active in bringing the need for state hospitals before the legislatures. Sometimes this was the work of individuals, but by 1830 many state medical societies had been founded and these usually urged their respective assemblies to action. Rush had once taken the cause of the insane into the newspapers; and a few public-spirited doctors still felt the need in the thirties to educate the laity on their responsibilities in this field. It is of some interest that the Connecticut Medical Society, in agitating for the founding of the Hartford Retreat, enlisted the support of the State (Congregational) Church, but this seems to have been unusual. A number of lay reformers participated in moves to establish hospitals—notably Horace Mann, who in 1828 backed the move to build the Worcester Hospital. But there was little evidence, prior to 1840, that the public was yet really aroused.

Perhaps this was because physicians were inclined to make a relatively

⁸⁰ See, e.g., K. F. H. Marx and R. Willis, *Decrease of Disease Effected by Civilization* (London, Longman, 1844).

⁸¹ This story is analyzed in Deutsch, *The Mentally Ill in America*, pp. 135 ff., 148.

dignified, scientific appeal. Such an approach may have been well adapted to the realistic temper of the eighteenth century; but the first half of the nineteenth was a time of increasingly romantic temper, when social reform must needs be presented in fervent and glowing terms. "Horrible examples," rather than statistics, were indicated. In the case of mental diseases, not even the "cult of curability" statistics were adequate. What was called for was a transfer from rational to partly emotional leadership—from a problem to a "cause"—such as had already been made in other reform drives. The calm criticisms which Jefferson had expressed in the early days of the antislavery movement, for example, had now been replaced by Garrison's fiery crusade. But the move to improve the treatment of mental patients had not yet found its Garrison.

Another limitation in medical leadership was the fact that physicians, although partly motivated by humane feeling, naturally focused their interests on patients they could see in the hospitals. They were less likely to look into conditions in society, less likely to be concerned with the social aspect of the whole matter, than were lay reformers. After all, that problem lay outside the professional province.

As a result of all these circumstances, building proceeded slowly during the twenties and thirties. A list of the states providing such institutions and the dates of their establishment in these years would run as follows: Kentucky (1824), South Carolina (1828), Virginia (the second hospital in this state, 1828), Ohio (1830), Massachusetts (1833), New York (1836), Vermont (1836), Maine (1840), and Tennessee (1840).⁸² Certain states continued to depend upon private hospitals. Meanwhile, in a few of the largest cities, the infirmaries of the old almshouses evolved into general municipal hospitals which provided wards or separate buildings for mental patients. In such an institution as the Philadelphia General—"Old Blockley"—this service has been maintained to the present day. In 1839, city "lunatic asylums" were opened in New York and in Boston. In these municipal institutions and even in some of the state asylums, however, a primarily custodial attitude prevailed long after 1840.

Occasionally an individual physician converted his home into a sort of private sanitarium, and in a few instances real institutions evolved in this way.⁸³ These necessarily served persons of property, and by avoiding the stigma of the asylum they may have done something to reconcile

⁸² Different dates are sometimes given for some of these asylums, see, e.g., *Am. J. Insanity*, I (1844), 81 ff.

⁸³ *Ibid.*, p. 84, Hurd, *Institutional Care*, IV, 384.

families with the idea of medical treatment. As there was no regulation of such places analogous to that of state hospitals, however, there was also danger of abuses in this practice.

As late as 1843 many states and territories still possessed neither public nor private mental institutions of any sort. Indeed, in that year there were only some twenty-four hospitals, of either type, devoted entirely to mental cases. Their total bed capacity was but 2,561,⁸⁴ and this for a national population of over 17,000,000. Even if one assumes that a similar number were cared for in general hospitals, the total inadequacy of facilities is apparent. By this time some figures had become available as to the incidence of insanity. In 1833 the Prison Discipline Society of Massachusetts estimated that there were about twelve thousand "lunatics" in the United States—a ratio of 1 to 1,000 of total population. Only a fifth of these were thought to be in institutions of any kind.⁸⁵

In the years immediately following this estimate, increasing European interest in social as well as vital statistics was reflected in this country by the formation of the American Statistical Association in 1839, and by the appearance of statistics on mental disease in the Census of 1840. Uncertain as the figures were, for obvious reasons, it is of some interest to note that 17,457 "insane and idiotic" persons were reported for that year, giving a ratio to the total population of 1 to 977.⁸⁶ Since it was admitted that many cases were not reported, it is obvious that the majority of the mentally ill were still at large, or were "put away" in huts, jails, or almshouses, much as they had been for ages past.

Actual conditions in the asylums reflected in part the general status of hospitals in that period, and in part the special interest in the care of the insane. These were years of extreme *laissez faire* in English-speaking countries, when governments were expected to restrict their functions to certain minimum protections. It is not surprising, therefore, that legislatures were economical, and that most of the early asylums were cheaply constructed and inadequately maintained. In consequence, many had the forlorn appearance of almshouses. Matters were made worse in some city institutions by corrupt political control. The majority of the asylums cared for from 70 to 150 patients; but several city

⁸⁴ According to the list given in the *Am J Insanity* (I, 82 ff.) for that year

⁸⁵ Hurd, *Institutional Care*, I, 411.

⁸⁶ *Am J Insanity*, I, 89 This ratio was higher than that reported for Latin Europe, but lower than that for the Germanic countries. By 1845, American estimates of the number of "lunatics" had risen to 20,000, Hurd, *Institutional Care*, I, 414.

and state hospitals housed from 250 to 350. Since there were as yet no trained nurses in the modern sense, and as nursing orders—either Catholic or Protestant—were not yet generally available in the United States, the attendants in asylums were a haphazard lot. At best, they were decent guards or “practical nurses”; at worst, crude keepers and “Sairey Gamps.”⁸⁷

Asylum superintendents were quite conscious of the need for improving the character of attendants and began to urge some instruction for this purpose. During the thirties, “directions for attendants” were issued at both the McLean and the Worcester Hospitals. Although training for nurses had been inaugurated in German universities before 1800 and Fliedner was at this time developing his program at Kaiserworth, no similar efforts were yet being made in the general hospitals of England or America. Hence the first interest in the training of nurses in these countries may be claimed for the early asylums.⁸⁸

The alternative between good and bad care depended largely on the purpose behind the erection of the hospital, and on the character of its superintendent. Where custodial interests predominated, conditions were not so good. The Kentucky State Hospital, for example, at first took only “dangerous” cases, and no doubt treated them accordingly. On the other hand, the majority of state asylums attempted to apply moral treatment in some degree, and a number approached closely to this ideal. In this respect they were ahead of most European institutions.⁸⁹ The McLean Hospital of Boston, for example, was described in 1836 as one where “no kind of deception, and, if possible, no restraint, is exercised upon the patients who are allowed every indulgence . . . not incompatible with the object for which they are sent hither. . . .”⁹⁰

Where good conditions obtained, they were due primarily to the efforts of the superintendents. Fortunately, the physicians who were leaders in attempts to establish mental hospitals were frequently placed in charge of them. This was not to be taken for granted, for prior to about 1840 it was customary to omit physicians from many offices which would

⁸⁷ On difficulties with politicians and attendants, see Joseph McFarland, “History of Nursing, Blockley Asylum,” *Medical Life*, XXXIX (1932), 632, “Historical Sketch of the New Orleans Charity Hospital,” *New Orleans Med. J.*, I (1844), 72 ff., J. C. Da Costa, “The Old Blockley Hospital,” in J. W. Croskey, *History of Blockley* (Philadelphia, F. A. Davis, 1929), pp. 130 ff.

⁸⁸ Franz May, *Unterricht für Krankenwärter zum Gebrauche öffentlicher Vorlesungen* (2d ed., Mannheim, Schwan, 1784), pp. 5 ff., Hurd, *Institutional Care*, I, 290.

⁸⁹ Hurd, *Institutional Care*, I, 289.

⁹⁰ Quoted in Marshall, *Dorothea Dix*, p. 79.

now be viewed as having a medical status. The public was long unconvinced that the doctor need be represented in licensing boards, in legal cases involving insanity, or in the management of hospitals. There was no particular awe for the doctor's status as an expert; indeed, the rise of medical sects, the riot of quackery, and the neglect of licensing laws in this very period suggest an actual decline in the public status of physicians.⁴¹ Just when skepticism about ordinary medical treatments was spreading among the laity, however, the superintendents of asylums were claiming wonderful results, and this may have preserved their prestige.

Whatever the explanation, a number of very able physicians became superintendents of asylums in this country at a time when English institutions were still managed by wardens in the tradition of the old prison system. This in itself was one of the great advantages in the American system.⁴² The record of the Galt family, which long presided over the first Virginia hospital, invites comparison with the Tuke dynasty at the York Retreat. Several of the early leaders, who will be discussed later in this volume, combined administrative ability with a broad interest in the welfare of their charges. At first extremely optimistic, they seem to have felt that the mere presence of a patient in a well-ordered institution would insure his cure. Their interests therefore often centered on administrative problems, rather than on those of a truly psychiatric nature.

In so far as they were concerned at all with questions of etiology, classifications, and methods of treatment, they tended to follow British and French leadership—as in the collection of statistics inspired by the Paris school. But, as we have seen, little progress had been made by 1843 in regard to workable classifications. There was not even any clear distinction between those who were defective—the feeble-minded and idiots—and those who were ill. Nor, in the early years of the state asylums, do their medical superintendents seem to have done much to follow the lead of European research in neurology, or in seeking local sites of mental disorders. They were handicapped here, as were all American physicians, by the popular aversion to autopsies,⁴³ and also by the constant pressure of administrative duties upon an overworked and underpaid staff.

The solution here would have been to set up chairs in medical schools,

⁴¹ R. H. Shryock, "Public Relations of the Medical Profession," *Annals of Med Hist.*, n. s., II (1930), 314 ff.

⁴² Hurd, *Institutional Care*, I, 294.

⁴³ See, e.g., Kenneth W. Rawlings (ed.), *Medicine and Its Development in Kentucky* (Louisville, Standard Printing Co., 1940), p. 159.

whose occupants could have combined private practice with some degree of research in the prevailing manner. But the medical profession, coming more and more under the spell of a localized pathology, was not interested in psychiatry. No training facilities or research encouragements were afforded in the schools, even for the future directors of mental hospitals. The latter, in turn, came to live isolated professional lives, and even to oppose psychiatric practice outside their walls.

Some attention, of course, had to be given to medical treatment within the asylums. Progress here was largely negative in character between 1820 and 1840, just as it was in relation to somatic conditions. The Paris school, having rejected theoretical pathological systems in favor of localization, also rejected the depletion procedures deduced from those systems. Bleeding was increasingly discouraged, and clinicians gradually became skeptical of the old pharmacy. These trends were followed in American centers, and the resulting nihilism expressed itself in mental as well as other hospitals. If this meant that old measures were abandoned before new were available, it was no more true in psychiatry than in other fields. During the forties, for instance, it was said that the only remedy employed in the Vienna General Hospital was cherry brandy. And the abandonment of bleeding in asylums was, in itself, a considerable step forward. There was also some caution in using drugs, although eventually hypnotics came to be used as a substitute for physical restraints.

Strictly speaking, there was a new mode of treatment, and that a psychological one, which was by this time available in the place of methods then being abandoned—the much-suspected “Mesmerism.” But Mesmer had been condemned in Paris because of at least the appearance of charlatanism. His potential significance seems as a result to have been quite overlooked before 1840 by American psychiatrists,⁴ though some popular interest developed which eventually played its part in the genesis of Christian Science.

So much for the achievements and limitations of the early asylums. But what of the great majority of the mentally ill who were denied either these achievements or these limitations? The actual disposal of most mental cases during the first half of the nineteenth century presents a picture more depressing, if anything, than that of earlier periods. The

⁴ He was referred to by Thomas C Upham in his *Outlines of Imperfect and Disordered Mental Action* (New York, Harper, 1840), pp 316 f., but only in a quotation of the criticisms of the famous investigating committee, appointed by the French Academy of Sciences, of which Franklin was a member

small number of real asylums remained isolated from general practice. In some cases this was in part their own fault. In certain instances the custodial motive was at first predominant, so that only the "dangerous" were admitted. In other cases, the emphasis on curability had an opposite effect, since there was then a disinclination to take apparently chronic cases. But by and on the large, the hospitals were simply too limited to supply the public need. This was true with the exception of the hospitals in a few large cities, and it must be remembered that American society remained predominantly rural long after 1840. The great mass of people lived on farms or in small towns, and in such surroundings the increasing population demanded more systematic provision for the mentally ill, and particularly for "insane paupers." In this situation, lacking mental hospitals, the only solution was to be found in some elaboration of the poor relief system inherited from colonial days.

Paupers, including both mental defectives and the mentally ill, continued to be auctioned off—either as individuals or as groups—to those who would support them at the lowest cost and then get as much work out of them as possible. Others might receive a little "outdoor relief," or be placed in jails or almshouses. Lack of uniformity in procedures, rising costs due to population increases, and humanitarian concern all combined to force state investigations during the 1820s. These revealed confusion and gross neglect of the paupers, and led to a demand for institutional protection. The solution was the poorhouse, long known in larger towns but now to be set up in all communities. It was to protect paupers from exploitation and exposure, and make them happy by honest toil; incidentally, it would rejoice taxpayers by bringing down the rates. By 1830, nearly all states encouraged the building of local poorhouses, and some made it compulsory. But instead of proving to be panaceas, the almshouses simply became catch-alls into which drifted all sorts of destitute folk—men and women, adults and children, sick and well, "normal" and "insane."⁴⁵ With little or no state regulation, inadequate funds, and no opportunity for segregation of different types, many local poorhouses reached an extremely low level, from which their victims had to be recovered by state institutions even during the present century.

As a result of the developments noted, general confusion still reigned in matters dealing with mental defectives and the mentally ill as late as

⁴⁵ Deutsch, *Mentally Ill in America*, p. 129; R. W. Kelso, *History of Public Poor Relief in Massachusetts, 1620-1920* (Boston, Houghton Mifflin, 1922), pp. 133 ff

1843. While a few were now cared for in decent state or private asylums, the vast majority were confined at home or in poorhouses and jails under the most abominable conditions. Public opinion was not only still unaroused, but some suspicion of the asylums was getting abroad and tended to limit their influence. Methods of commitment were extremely lax and there was fear of their abuse. The very demand for bigger and better institutions, as well as the publication of the first statistics, aroused some apprehension about an increase in mental disease. This can be observed, for example, in a widespread illusion that perverse sexual practices were crowding the asylums with victims of their own vices. Here again was the persistent feeling that the mentally ill were an inferior lot, but this expression of it was said to rest on the testimony of superintendents, as well as upon the best medical authority.⁴⁶ What reformers sweetly termed "American amativeness" was evidently driving the country morally—and therefore mentally—to the dogs!⁴⁷ In consequence, there appeared a popular literature on the exalted theme of "What a Young Man Should Know" which deserves a place, however humble, in the history of mental hygiene.⁴⁸

There were other evidences of a growing public concern about mental conditions, some of it on a higher level. The interest of prison societies and of statisticians has already been noted. In 1840 Harper and Brothers decided that a volume on insanity ought to be included in their "Family Library," and Thomas C. Upham of Bowdoin College met this need in the hope of contributing to popular understanding. Upham was a philosophical psychologist of the old school rather than a physician, and his work was therefore more systematic but less original than Rush's earlier studies.⁴⁹ Nevertheless, Upham had read widely in psychiatric literature, and his book is not without interest. Presumably just because he was not a doctor, he rejected the growing medical emphasis upon localized, physical pathology and declared emphatically:

We do not agree with some respectable writers in considering Insanity as being, in its basis, exclusively a physical disorder. We have no hesitancy in

⁴⁶ See, e.g. Thomas Beddoes, *Hygeia* I (Bristol, Mills, 1802), 34, M. P. Tissot, *Oeuvres* (Paris, Allut, 1809), III, 248, 291.

⁴⁷ For example, see the *Boston Moral Reformer*, I (1835), 64.

⁴⁸ Note the various writings on this theme by Dr. William Alcott, Sylvester Graham (of "Graham crackers" fame), and Dr. T. H. Trall.

⁴⁹ This is the opinion of Fay, *American Psychology before William James*, p. 198.

admitting the doctrine that there may be other causes of mental irregularity, more remote from common observation, and more *intimately connected with the mind's interior nature and secret impulses*.⁵⁰

Proceeding in these terms, and also on the assumption that the abnormal could be understood only in relation to the normal, Upham then outlined his whole faculty psychology. This he had already done in a systematic work, but in the later volume the various mental irregularities were discussed against the background of "normal" behavior. This involved a classification of mental diseases in terms of faculties, which, however systematic, necessarily suffered from the limitations of Upham's psychology. His basic ideas deserved serious consideration, but in practice his classifications probably were less useful to psychiatrists than their own symptomatic concepts—vague as the latter still were. As a layman, moreover, Upham knew only the therapeutics of an age that was passing. Visual illusions, for example, he thought could be cleared up by periodic bleedings.⁵¹ Whether he succeeded in enlightening the public is difficult to say; but so far as it went, his work was calculated to arouse an objective and humane attitude.

One of the few themes which Upham overlooked, since he was no more a lawyer than a physician, was that of the legal implications. This was unfortunate, for, in addition to the problem of commitments, uncertainty continued in the whole matter of criminal responsibility. The assumption that a clearly "demented" person was not responsible went back to classical times, but how to distinguish between sanity and insanity was another question. American courts usually followed English precedents of the past hundred years, by which legal tests had been established without relationship to psychiatric realities.⁵² Psychiatrists themselves were naturally the first to become concerned about this problem, and in 1838 Isaac Ray published the pioneer American *Treatise on the Medical Jurisprudence of Insanity*. Here was the advent of an effort, continued to the present time, to persuade jurists to reconcile their procedures with medical findings.⁵³ Pending progress in this direction, many of the mentally ill were imprisoned for crimes or, if sent to asylums, were simply

⁵⁰ *Outlines of Imperfect and Disordered Mental Action*, p. 43. Italics my own.

⁵¹ *Ibid.*, p. 124.

⁵² Hurd, *Institutional Care*, I, 321 ff.

⁵³ Zilboorg, *Mind, Medicine and Man*, pp. 249 ff.

confined there with all other types of patients. Protests against the situation were received from prison authorities before 1840.⁶⁴

Despite all these difficulties, the country balanced on the brink of progress in 1843. The cumulative effect of decades of humanitarian striving could be observed in increasing public response. As Protestant churches lost interest in theological distinctions, their more liberal leaders turned toward a "social gospel." This was most marked with the Unitarians, whose quasi-scientific conviction of the possibilities of *this* world provided a more dynamic impulse than the calm humanitarianism of the Quakers. Reform was "in the air" as never before.⁶⁵ This had its extreme and ludicrous phases, to be sure. "We learn from the papers," observed William Alcott in 1835, "that the American Seventh Commandment Society, the New York Female Benevolent Society, the New York Ladies' Moral Reform Society, and the Anti-Tobacco Society held their annual meetings at New York about the middle of May, and that some of these meetings were interesting."⁶⁶ But at the worst, these "uplift" groups were but the lunatic fringe of significant social movements.

So far as psychiatry proper was concerned, little lay in the immediate future; but the social background to this science was soon to undergo far-reaching changes. The humanitarian urge to provide proper asylums and the professional desire to administer these well were about to find effective expression. It was on a raw March day in 1841 that Dorothea Dix—an ex-school teacher reared in the social idealism of the Unitarians—first observed by chance the sufferings of "lunatics" in the jail of East Cambridge, Massachusetts. From that day forth she became an earnest and persistent advocate of the proper care of the mentally ill, displaying a genius for just the type of appeal which reached the hearts of romantic Victorians. Legislatures responded with enthusiasm, and asylums appeared in Dorothea's wake throughout the Union.⁶⁷ Miss Dix may well be viewed as the greatest social reformer in American history, and her influence reached overseas as well as into all parts of this country. Her

⁶⁴ The first asylum for "the criminal insane" was provided at Auburn, N. Y., 1855. Hurd, *op. cit.*, I, 349. See also Harry E. Barnes, *Development of Penology in Pennsylvania* (Indianapolis, Bobbs-Merrill, 1927), p. 341.

⁶⁵ For the over-all picture, see C. R. Fish, *The Rise of the Common Man, 1830-1850*, pp. 256 ff. Vol. VI of the series, *A History of American Life*, edited by D. R. Fox and A. M. Schlesinger (New York, Macmillan, 1927-1936)—the most adequate treatment of American social history

⁶⁶ *Boston Moral Reformer*, I, 225

⁶⁷ Marshall, *Dorothea Dix*, pp. 61 ff, 98 ff

crusade was under way before 1843, but as the fruits thereof appeared later, they will be considered in another chapter.

Meantime the medical superintendents who were about to found the organization later known as the American Psychiatric Association were already concerned with the improvement of their institutions. As the states founded hospitals, this group would devote itself to their proper management. Here was the American contribution to this age: the humane administration of institutions in a manner not yet evolved in most European countries.

If Americans contributed little to the science of psychiatry in this era, two circumstances should always be recalled. First, the lag in research was typical of native medicine in general, and in no wise peculiar to psychiatry. Second, the evolution of an institutional system, while not a contribution to science as such, was of potential value in providing the facilities for later investigations. Hospitals would in time function in psychiatric studies, just as they already had for decades in other medical fields. It may be concluded, therefore, that in the long run the situation in the United States on the eve of the formation of the Association was of significance for psychiatry as well as for humanitarianism.

HENRY E. SIGERIST

PSYCHIATRY IN EUROPE AT THE MIDDLE
OF THE NINETEENTH CENTURY

AT THE middle of the nineteenth century psychiatry was still a very young medical discipline. How young it actually was becomes easily apparent when we remember some discoveries that were made and some events that took place a hundred years ago in other fields of medicine and biology.

In 1838 Schleiden described the plant cell and its nucleus, and Johannes Muller published his treatise on tumors. In 1839 Schwann described the animal cell, and in 1840 the great chemist Liebig made known his studies on agricultural chemistry which became the starting point of the science of nutrition. In the same year Henle published a most illuminating treatise on miasmata and contagia in which he outlined a theory of contagious diseases.

In 1842 Robert Mayer stated the law of the conservation of energy; Wöhler described the synthesis of hippuric acid; and Edwin Chadwick in England published his *Report on the Sanitary Condition of the Labouring Population of Great Britain*, which resulted in the passing of the Public Health Act, the beginning of a powerful public health movement.

In 1846 ether anesthesia was introduced by Morton, and the following year chloroform anesthesia by Simpson. The same year Claude Bernard published his studies on the physiology of the pancreas, inaugurating a series of most important physiological discoveries, and in 1847 Virchow launched the *Archiv für pathologische Anatomie*.

General health conditions were still bad enough, but medicine had become scientific and was forging the weapons to improve them. From Vesalius to Harvey, to Morgagni and Bichat medicine had acquired a new foundation and had developed a new and infinitely productive method of research. The symptoms of disease appeared as the *functio laesa* of anatomically changed organs. The clinicians of the French school of the early nineteenth century observed the clinical course of diseases, wrote case histories, performed autopsies on deceased patients, wrote autopsy reports, and, comparing the latter with the case histories, were able to establish well-defined disease entities that were not determined by their symptomatology alone but by the underlying anatomical lesions.

Diagnostics became the art of recognizing anatomical changes in the

patient by such means as percussion and auscultation. The application of statistical methods also developed greatly in the French school and permitted a safe prognosis. Surgery was direct anatomical therapy, and with the developing physiology and chemistry a new pharmacology was soon to be born.

Most of the contagious diseases still could not be defined anatomically, but their symptomatology was so characteristic that the majority of them had already been recognized as entities in the Middle Ages or in the Renaissance, and a few decades only were needed to have them further defined on an etiological basis.

Thus at the middle of the nineteenth century medicine from an *ars coniecturalis* was becoming a scientific discipline. As a matter of fact, development had progressed so far at that time that an increasing specialization of research and, consequently, of teaching was setting in. Johannes Müller could still be professor of anatomy, physiology, and pathology all in one, and he was able to make lasting contributions to every one of these fields. But when he died in 1858 three chairs and three departments had to be created to take the place of the former one.

Compared with these developments, psychiatry indeed appears as a very young medical discipline.² In general medicine the use of hospital patients for research and instruction can be traced back to the sixteenth century. In the early eighteenth century Boerhaave gave a strong impetus to clinical investigation, and the Vienna school was able to collect an enormous amount of clinical observations in the *Allgemeines Krankenhaus*. As long as mental patients were confined to asylums that hardly differed from jails, as long as they were chained like animals, were not examined and were scarcely treated, clinical investigation in the field of mental diseases was impossible, or was at best limited to the observation of a few non-hospitalized patients. The dramatic liberation of the inmates of the Bicêtre by Pinel in 1793 was therefore infinitely more than a humanitarian gesture. It was the beginning of a movement that made

² For the general history of psychiatry, see Gregory Zilboorg, *A History of Medical Psychology* (New York, W. W. Norton, 1941); Emil Kraepelin, *Hundert Jahre Psychiatrie* (Berlin, Julius Springer, 1918). For France, see René Semelaigné, *Aliénistes et philanthropes* (Paris, G. Steinheil, 1912), and *Les Pionniers de la psychiatrie française avant et après Pinel* (Paris, J.-B. Baillière et Fils, 1930-32, 2 vol.) For England, see Daniel Hack Tuke, *Chapters in the History of the Insane in the British Isles* (London, K. Paul, Trench & Co., 1882). For Germany, see Theodor Kirchhoff, *Deutsche Irrenärzte* (Berlin, Julius Springer, 1-21-24, 2 vol.).

the patients of mental hospitals available for psychiatric research and subsequently for the training of psychiatrists.

The middle of the nineteenth century witnessed a regular outburst of activities. After fifty years of research that had produced a great volume of literature, psychiatry was broadening and was reaching ever widening circles in every country. Within twelve years seven psychiatric journals were founded in five countries: in 1843 the *Annales Médico-psychologiques* in France, in 1844 the *Allgemeine Zeitschrift für Psychiatrie* in Germany and the *American Journal of Insanity*; in 1848 the *Journal of Psychological Medicine and Mental Pathology* in England; in 1853 the *Nederlandsch Tijdschrift voor Gerechtelyke Geneeskunde en voor Psychiatrie* in Holland, and the *American Psychological Journal*; and in 1854 the *Correspondenzblatt der deutschen Gesellschaft für Psychiatrie und gerichtliche Medizin*. It is indeed remarkable that such a young country as America, and at a time when general medicine was at a pretty low ebb, was represented by two journals, thus documenting the active part it was taking in the development of psychiatry. It must be remembered that neither anatomy, physiology, nor pathology had its own journal in America at that time.

During the eighteenth century the American physician who went to Europe for postgraduate study went preferably to Scotland and England. During the first half of the nineteenth century Paris was the mecca of American medical students and doctors. Paris with its great past carved in every stone, seat of the great Revolution and of the Napoleonic empire, oscillating constantly between revolution and reaction, appeared as the capital of Europe. Bichat, Corvisart, Laennec, benefiting by the new institutions created by the Revolution, had inaugurated a great medical tradition, and the clinician Louis—who was interested in statistics and therefore could talk in figures—had a special appeal to American students.

Psychiatric studies centered around three institutions: Bicêtre, the Salpêtrière, and Charenton. In all of them Pinel and Esquirol still exerted the dominating influence, and it is no exaggeration to say that at the middle of the nineteenth century almost all French psychiatrists were students of Pinel, of Esquirol, or of both. In Bicêtre Pinel had started his reform work in 1793, at the height of the Revolution. He was transferred two years later to the Salpêtrière, the women's asylum, where he continued his work; but Bicêtre remained a center of psychiatric studies with

such men as Pariset, Ferrus, Voisin, and Scipion Pinel, the son of Philippe. At the Salpêtrière were Ferrus and Esquirol, also Pinel's pupils; after Pinel's death in 1826 the tradition was carried on by Pariset, Falret, and Georget; a generation later, Charcot made that hospital a new center of attraction. In 1825 Esquirol took charge of the asylum at Charenton, from which he exerted a far-reaching influence until 1840, the year of his death.

These French doctors contributed a great deal toward making psychiatry a recognized medical discipline. The task they had to perform was a tremendous one. Psychiatry was not represented on the medical faculty. Pinel was professor of internal medicine, and the instruction he gave at the Ecole de Médecine dealt with fevers and other internal diseases, where he, a timid speaker, had to compete with the boisterous Broussais. Those who wished to hear Pinel talk on mental diseases had to attend his ward rounds at the Salpêtrière, where instruction was quite unofficial. Regular clinical teaching began in 1817 with Esquirol, a brilliant and most persuasive speaker, and was continued later at Bicêtre by Ferrus. But neither of them was a professor of the *Faculté*. In other words, the rank and file medical student had no instruction in psychiatry. Oliver Wendell Holmes studied medicine in Paris in 1833 and 1834, but it never occurred to him to attend psychiatric courses; it was not done unless a man had a special interest in the field.

All these early psychiatrists were medical directors of large institutions, and it was a tremendous task to turn these "asylums of insane" into hospitals for mental patients. They all had extensive administrative duties. Esquirol made a survey of all French asylums on the basis of which he presented a report to the Ministry of the Interior in 1818, with recommendations for their improvement. In 1823 he was appointed inspector of medical schools. Ferrus was inspector general of mental asylums from 1830 on. Their combined efforts resulted in the passing of the law of June 30, 1838, which gave mental patients a new legal status. The law was hailed abroad as "the greatest, most far-reaching event in France in the field of objective psychiatry."² It placed all mental institutions, public and private, under supervision of the central government. It regulated the transportation, admission, and discharge of patients. Under no circumstances were patients to be transported with criminals or to be

² *Allgemeine Zeitschrift für Psychiatrie und psychisch-gerichtliche Medizin*, I (1844), ix.

housed, even temporarily when on a journey, in jails. "The law," said Esquirol, who with Ferrus was largely responsible for it, "is a humanitarian law, loudly called for by honest people; it makes an end of the arbitrary measures to which mental patients were subjected. . . . For the first time the law treats mental patients as it does other sick people."⁸

A royal ordinance issued the following year regulated the administration of mental hospitals. The large institutions had an administrative and a medical director with a full-time medical staff and the medical director was required to live in the hospital. All this greatly contributed toward making psychiatry a medical specialty in which the doctor could find a career.

The French psychiatrists obviously followed the general trend of the French clinical school. Pinel was still deeply rooted in the eighteenth century, from which he had absorbed not only the humanitarian ideals but also the desire for classification, for bringing the multiple phenomena of nature into a system. He was, after all, a student of Montpellier, and although Boissier de Sauvages had just died when Pinel arrived, his influence was still strongly felt. Pinel's major work, the *Nosographie philosophique* of 1798, was an attempt to bring all diseases into a logical system. The nervous diseases constituted one of five sections, but while previous classifications were based on symptomatology almost exclusively, Pinel—following the trend of which Bichat was the foremost exponent—considered symptoms in relation (although a vague one) with physiology and anatomy. He was a phenomenologist if there ever was one, a keen observer of clinical symptoms, and the desire for classification that he shared with such men as Cuvier, his colleague at the Academy of Science, was not a mere mental exercise. When he claimed that the clinician's first task was to determine the true character of a disease and the place it occupies in the nosologic system, he meant that such a diagnosis determined to a large extent the treatment, which in the case of mental diseases was to be "moral and physical."

Pinel's clinical colleagues in Paris were Corvisart and Laennec, who followed a totally different line. They succeeded in greatly advancing the knowledge of diseases of the circulatory and respiratory systems by correlating clinical symptoms with autopsy findings. They inaugurated a method that dominated the French clinical school and proved infinitely

⁸ Quoted from René Semelaigne, *Aliénistes et philanthropes*, p. 458

fruitful. Anatomy, physiology, and general pathology explained the character of the various diseases. The application of this method to psychiatry became the program of most French psychiatrists after Pinel.

The introduction to the first volume of the *Annales Médico-psychologiques* is perhaps the best summary of the French psychiatric program at the middle of the nineteenth century. The subtitle is already characteristic: *Journal de l'anatomie, de la physiologie et de la pathologie du système nerveux*. The editors (Baillarger, Cerise, and Longet) did not deny the significance of psychological factors, and in their opinion the task was "to seek the laws by virtue of which our ideas, emotions, sensations, and motions are produced normally so as to discover the pathogenic laws by virtue of which these ideas, emotions, sensations, and motions become distorted in mental illness and in the neuroses." But "pathology of the mind is closely connected with moral and intellectual physiology, which itself is closely connected with the anatomy, physiology, and pathology of the nervous system."

It is no wonder that French psychiatry at that time remained earth-bound and succeeded best in the neurological field and in the interpretation of organic psychoses. It should also be mentioned in this connection that, beginning with Pinel but particularly from Esquirol on, France was the leader in the medico-legal field, in an earnest endeavor to rationalize and humanize the administration of justice, a problem which will be discussed in detail in a later chapter of this book.⁴

In England conditions in mental asylums were as bad in the eighteenth century as they were in France. The three major institutions—Hanwell, St. Luke's, and Bethlehem (known as Bedlam)—were appalling, and it is well known that in the last institution patients were shown to visitors for their amusement upon payment of a fee. It was a brutal age, with refinement at the top of society and great misery at the bottom. Whoever dropped out of society, be it on account of poverty, illness, or crime, could not expect any mercy. But England, like France, had a strong philanthropic movement, although it was motivated more on religious grounds than in France, where it was rather the outcome of a rational philosophy. John Howard investigated prisons and made recommendations for their reform. Jonas Hanway endeavored to improve conditions in the parish workhouses, and many other philanthropists were active along such lines. They accomplished little during their lifetime, but they

⁴See Dr. Zilboorg's chapter, "Legal Aspects of Psychiatry."

were sowing the seed, when the great scare of the French Revolution stirred the ruling classes into action, some of the postulates of these reformers were realized.

In the treatment of mental patients William Tuke did the pioneering work in England. He was an immediate contemporary of Pinel, not a physician but a merchant, a member of the Society of Friends. His reform was less dramatic, but the York Retreat that he founded and that was opened in 1796 was the example of an institution in which mental patients were treated kindly as sick human beings. It demonstrated that there was no need for dark cells and brutal restraint in the handling of such patients.

Demonstrations unfortunately are not enough to overcome the forces of inertia, and conditions remained very bad for a long time. England was the first country to feel the full impact of the Industrial Revolution. The population increased tremendously, and while industry created wealth for a few, it kept the masses on a sub-subsistence level. How bad conditions were is illustrated graphically in such documents as Chadwick's *Report on the Sanitary Condition of the Labouring Population of Great Britain*, in 1842, or Engel's work on the *Condition of the Labouring Classes in England*, in 1845. The great majority of mental patients referred to asylums were indigents, who often were admitted in a condition of complete starvation.

The counties were supposed to establish asylums for indigent patients but as late as 1844 only twenty-nine counties had—mostly quite inadequate—institutions; five had asylums erected on public and charitable funds; and twenty-one had no facilities whatsoever, not even private homes. Indigent mental patients were therefore frequently turned over to the parish workhouses operated under the Poor Law, where they lived under most degrading conditions with paupers and aged people, without examination or treatment, sleeping two on a couch. Of the 16,821 indigent mental patients kept in institutions in 1844 the majority, namely 9,339, were in workhouses, 4,155 in county asylums, and the rest in various other institutions.⁵

The 136 private homes in existence as hospitals at that time were another sore spot in the system. Most of them were owned and operated by

⁵ The figures are from Battelle, "Rapport au Conseil Général des Hospices de Paris sur les établissements d'aliénés d'Angleterre et sur ceux de Bicêtre et de la Salpêtrière," *Annales Médico-psychologiques*, IV (1844), 390-455.

laymen for profit. They had to be licensed, the law required that commissioners inspect provincial private institutions twice a year, county asylums once a year, and that they present a report to the Lunacy Commission on existing conditions with recommendations for their improvement. English legislation in this field, starting in 1828, preceded that of all other countries, but the law was disregarded just as were the early factory laws. Inspection of asylums was just as lax as the inspection of factories, although the commissioners were paid a guinea an hour. Abuses were frequent, and it was relatively easy to have an undesirable family member disappear into one of these private homes. In the session of the House of Commons of September 21, 1841, a member of Parliament in the course of a stormy debate violently attacked the existing laws and pointed out that it would be easy to find at least one hundred individuals in private asylums who were just as sane as any member of the House.⁹

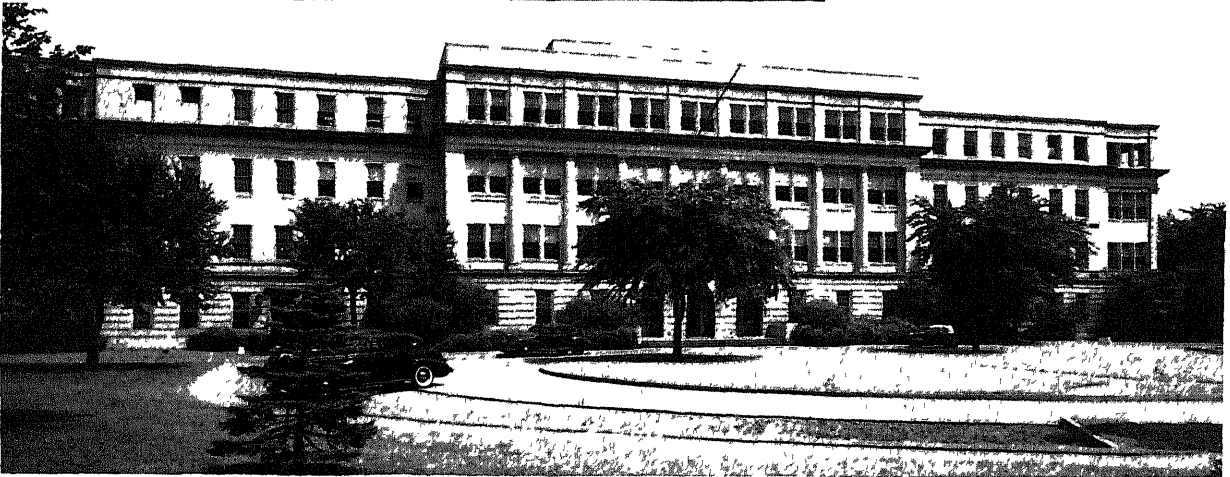
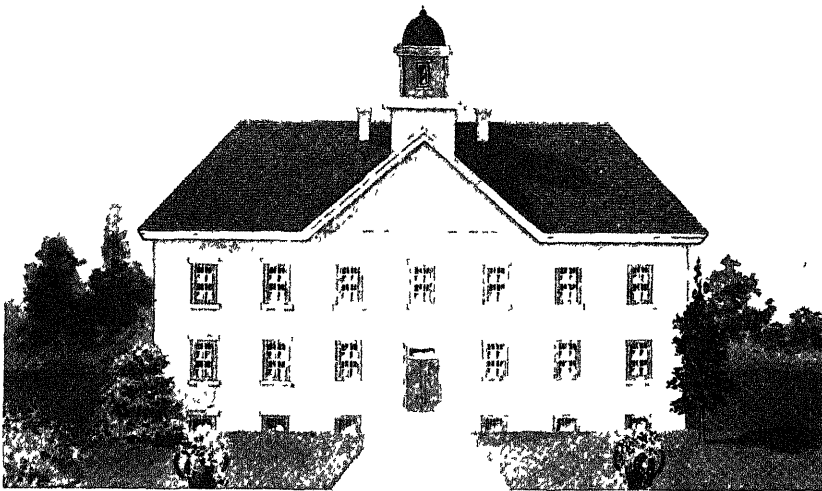
The public health movement of the 1840s that led to the passing of the Public Health Act of 1848 had repercussions in the psychiatric field also. A Royal Commission headed by Lord Ashley investigated all mental institutions and in 1844 presented a report which among others called for the establishment of more mental hospitals, for resident physicians in every one, and for the separation of curable and incurable patients.

Conditions gradually improved, particularly because the medical profession was beginning to take a more active interest in mental diseases. In 1840 clinical instruction in psychiatry was given at Hanwell for the first time to ten students who had been carefully selected from the various hospital schools of London. Thereafter clinical lectures were given at St. Luke's and Bethlehem also. In 1841 the Medico-psychological Association was founded, which was the pioneer organization in the field.

British medicine toward the middle of the nineteenth century was developing slowly and steadily along the clinical line, following the tradition of Sydenham. It had not had the violent experience of the French Revolution, that created new medical institutions overnight. Nor did it experience the intoxication with *Naturphilosophie* as did the Germans, who once the dream was over rushed headlong into the laboratory. There was no English school at that time, as there was a French school or a Viennese school or later a German school. The British were strong individualists, and the country produced strong individualities in medicine as in all other fields. They defeated Napoleon but took inspiration from Cor-

⁹ *Allgemeine Zeitschrift für Psychiatrie*, I (1844), xix

EASTERN STATE HOSPITAL
WILLIAMSBURG
VIRGINIA



PENNSYLVANIA
HOSPITAL
(NEW)

PENNSYLVANIA
HOSPITAL
(OLD)



visart, Laennec, and other members of the French school. They accepted the new anatomical approach to clinical medicine, although somewhat reluctantly and not too enthusiastically. The Irish were quicker than the English. They made great individual contributions; we need only recall the names of such men as Robert Graves, William Stokes, Thomas Hodgkin, Richard Bright, or Thomas Addison, names that have become part of our medical nomenclature.

Just as general clinical medicine followed the tradition of Sydenham, the study of nervous diseases was for a long time under the influence of Thomas Willis. Physicians made clinical observations and dissected the nervous system, and while their findings could hardly be correlated with mental symptoms, yet they yielded results in the field of organic diseases. Thus neurology was advanced in many ways. In 1808 John Cheyne described acute hydrocephalus; in 1815 John Clarke, infantile tetany, in 1817 James Parkinson, paralysis agitans. Alcoholic neuritis was described by James Jackson in 1822, and in 1828-29 William Wood published his observations on neuromas. As early as 1813 Thomas Sutton had written a classical monograph on delirium tremens.

In the psychological field the studies of James Prichard were extremely fertile. He is usually remembered for his anthropological work, but his *Treatise on Insanity* published in 1835 is no less important. It introduced the concept of *moral insanity*, which caused so much controversy in medico-legal practice.

Pinel had liberated the mentally sick from their chains but all too often the chains were replaced by straitjackets, and psychiatrists generally assumed that it was impossible to handle violent patients without means of coercion. It was therefore an equally revolutionary step when John Conolly, from 1839 on, began to treat patients at the Hanwell Asylum without any mechanical restraints. He wrote a book on the subject in 1856⁷ that was received with great skepticism. It must be remembered that at that time there were still psychiatrists who found it necessary to "punish" patients with birch rods.⁸ But Conolly's plan was accepted by some who even tried open-door treatment, and tried it successfully. Looking back today we admire Conolly's courage and foresight and justly consider him one of the great pioneers.

In the meantime the York Retreat remained the shining example of a

⁷ *The Treatment of the Insane without Mechanical Restraints* (London, Smith, Elder, 1856).

⁸ See *Allgemeine Zeitschrift für Psychiatrie*, II (1845), 301.

modern, humane hospital for mental patients. It was visited every year by scores of physicians from continental Europe and America and exerted by the mere force of its example a far-reaching influence that was particularly felt in America. The administration of the Retreat remained for generations in the Tuke family. The fourth of the name, Daniel Hack Tuke, was the first who became a doctor and served the Retreat as a psychiatrist. Together with John C. Bucknill, he wrote a *Manual of Psychological Medicine* that was published in 1858 and remained for a long time the authoritative book on the subject.

At the middle of the century England's contribution to psychiatry was not so much to be sought in the scientific field as rather in the humanizing of the treatment of mental patients. And this was a great contribution indeed.

One last aspect remains to be mentioned briefly in this connection. Sober and solid as British medicine was as a whole, it had a certain receptiveness to extravagant doctrines. This was the result of the British concept of freedom that permitted quackery as long as it did not become a public menace. Phrenology and mesmerism found in England a fertile ground. But British common sense disrobed mesmerism of its magical apparatus, while preserving and developing its real content, namely hypnotism. In 1843 a surgeon, James Braid, published a book under the unusual title *Neurypnology, or the Rationale of Nervous Sleep*, in which he described the phenomena and mechanism of hypnotism. The book was widely read, particularly in France where hypnotism was soon to play a great part in the schools of Charcot and Bernheim. The same year another surgeon, John Elliotson, reported on *Numerous Cases of Surgical Operations without Pain in the Mesmeric State*. He had not only performed operations on hypnotized patients but had recognized that hypnotism, the mesmeric state, could be used with advantage in the treatment of hysteria. His friends Dickens and Thackeray understood him, but his colleagues looked at him scornfully. In 1846 a surgeon in the Indian service, James Esdaile, reported on *Mesmerism in India, and Its Practical Application in Surgery and Medicine*.

Hypnotism focused the attention of physicians on the neuroses, and was soon to be developed into a method that gave access to the unconscious.

At the middle of the nineteenth century German medicine was just emerging from a romantic period during which it had been dominated by philosophy. The German physicians realized that they were far behind

those in other countries. They rapidly assimilated the experiences and methods of their neighbors and threw themselves into clinic and laboratory, with the result that German scientific medicine soon held a leading position in the world.

Many physicians had taken a very active part in the revolutionary movement of 1848, and the failure of the Revolution, while it frustrated their political ambitions, drove them into research. Rudolf Virchow is the outstanding example. The scare created by the Revolution, moreover, was strong enough to force certain necessary reforms.

The transition is already apparent in Johannes Muller. Deeply imbued with natural philosophy in his youth, he gradually liberated himself from the shackles and became a true scientist. The physiologists who followed him—Helmholtz, du Bois-Reymond, Ludwig—were leaders of German scientific medicine.

It was a strange period, that period of romantic medicine, and typical of Germany, a country whose medicine had never had a steady development but had always swung from one extreme to the other, violent, boisterous, and aggressive in whatever line it happened to take. While French physicians were observing patients in the hospital and performing autopsies in the laboratory, while English doctors were engaged in clinical investigation, the Germans sat at their desks and wrote big books on the nature of disease and of the world at large. As a whole, it obviously was a sterile period, but it undoubtedly had repercussions in psychiatry in that it drew the attention of medicine to the neglected field of mental diseases.

Medicine was considered one aspect of philosophy, and so was psychology. The speculations of the romantic physicians centered around man, in health and disease, around man's body, soul, and mind. It is obvious therefore that diseases of soul and mind seemed just as important as diseases of the body. This explains why so many books were written on mental illness during that period. It also explains why Germany produced psychiatric journals sooner than any other country. As early as 1799 Röschlaub published a *Magazin für Psychologie und Medizin* that continued to appear for ten years. In 1805 Johann Christian Reil, together with the philosopher Kayssler, started a *Magazin für die psychische Heilkunde*, of which only one volume came out, but the following year Reil started another periodical, *Beiträge zur Beförderung einer Kurmethode auf psychischem Wege*, of which the philosopher Hoffbauer was

co-editor. Most productive was the versatile Friedrich Nasse, who created no fewer than four psychiatric journals: in 1818 *Zeitschrift für psychische Aerzte*, which from 1823 to 1826 was issued as *Zeitschrift für Anthropologie*; in 1830 *Jahrbücher für Anthropologie und zur Pathologie und Therapie des Irreseyns*; in 1837, with Jacobi, *Zeitschrift für die Beurtheilung und Heilung der krankhaften Seelenzustände*.

Thus in the first half of the nineteenth century there was in Germany no lack either of interest in mental diseases or of publications on the subject. The trouble with this literature was that it was purely speculative, written by physicians and philosophers who had little or no practical experience with patients. The French and English psychiatrists of the period were directors of large mental hospitals who lived in daily contact with patients. The Germans were professors of medicine who saw a mental patient only incidentally. Asylums had not been reformed yet and were in appalling conditions. Patients were in the care of keepers and were hardly ever seen by a doctor. Asylums were therefore not yet open for psychiatric investigation. Then too, it was often the outright philosophers like Kant who wrote on psychiatric subjects. They felt perfectly competent to do so, since psychology, like medicine at large, was part of philosophy. Even Johann Christian Reil, who was probably the best of the early group of psychiatric writers, had little practical experience. He was a good anatomist, a vitalist who in 1796 founded the first journal of physiology, a brilliant teacher of medicine at the universities of Halle and Berlin, a humane physician who made a strong plea for improving the conditions of the mentally sick and advanced the idea of the separation of curable and incurable patients into different institutions. But, unlike Pinel, he never lived in the hell of an asylum. He saw the problems from outside, and many of the treatments he recommended were fantastic because he had never tested them himself.

There are many captivating psychological observations in this early German psychiatric literature. Some case histories of Ideler are models of the kind;⁹ he was in charge of the psychiatric division of the Charité in Berlin and was in close touch with patients. Taken as a whole, however, the romantic, idealistic, philosophical, and moralistic period of German psychiatry contributed little to the advancement of the subject, and the country for a long time was behind France and England. The

⁹ *Biographien Geisteskranker in ihrer psychologischen Entwicklung dargestellt* (Berlin, E. H. Schroeder, 1841).

reorganization of mental hospitals was slow and was greatly handicapped by the fact that Germany had no central government but consisted of a multitude of small states, so that uniform legislation for the protection of the mentally sick was impossible. While some southern states like Württemberg and Baden were fairly advanced in matters of social welfare, others remained backward for a long time to come. In Prussia, the largest German state, the care of the mentally sick was left to the provinces, so that the development was very uneven in that state also.

By the middle of the nineteenth century the pendulum had swung back, with the same violence with which German medicine had embraced idealistic speculations, it now entered the sober grounds of laboratory and clinic. The dominating personality of Virchow made pathological anatomy and physiology the foundation of medicine. In 1846 Moritz Romberg wrote an epoch-making treatise on nervous diseases.²⁰

Wilhelm Griesinger inaugurated a new period in German psychiatry. Griesinger was thoroughly familiar with French and English medicine. He had traveled widely all over Europe and the Near East, where he was for a while in charge of the medical institutions of Egypt. He began his career in the mental hospital Winnenthal, which became one of the best-administered institutions of the country. Later in Tübingen Griesinger was closely associated with the clinician Wunderlich, whose *Archiv für physiologische Heilkunde*, founded in 1841, was in the process of annihilating the rear guard of the romanticists; this was a battle in which Griesinger took a very active part. In the same journal he published a series of masterly papers on physiology and pathology of the brain, reflex actions, and similar subjects. A professor in Tübingen, Kiel, Zürich, in 1864 he was finally called to the University of Berlin, which attracted the best minds of the country.

Griesinger was a fervent advocate of the nonrestraint system, and it is largely due to his influence that conditions in the mental hospitals of Germany improved rapidly during the second half of the century. His treatise *Die Pathologie und Therapie der psychischen Krankheiten* was the authoritative book for many decades. First published in 1845, it was issued in new and revised editions until 1892 and was translated into French and English. It has often been said that Griesinger's was a psychiatry without psyche. Indeed, it is true that to the men of his generation psychology had become primarily physiology of the nervous system.

²⁰ *Lehrbuch der Nervenkrankheiten des Menschen* (Berlin, A. Duncker, 1846).

His endeavor to correlate clinical pictures with anatomical findings and physiological processes was obviously not always successful. Yet after the period of speculation through which Germany had gone, men of Griesinger's frame of mind were a necessity.

As far as the incidence of mental illness at the middle of the nineteenth century was concerned, for obvious reasons we have no accurate statistics. There are, however, statistics of the number of patients hospitalized in various countries. They reflect not so much the incidence of illness as rather the facilities available, since it seems to be the rule that mental hospitals are always filled to capacity.

Battelle, in the report on English institutions previously mentioned,¹¹ gives the following figures:

In 1844 the number of mental patients hospitalized in England and Wales was 20,983 or 1 per 980 of the population. The corresponding figure for Scotland was 4,500 or 1 per 573.

In France in 1841 the number of mental patients hospitalized in public institutions amounted to 19,738 or 1 per 1,733 of the population. These figures do not include the patients in private hospitals. Battelle thinks that their number was not large, however.

In Belgium at the same time there was 1 hospitalized patient per 816 of the population.

Damerow in the preface to the first volume of the *Allgemeine Zeitschrift für Psychiatrie* of 1844 mentions that the number of mental patients in Saxony in 1836 was 1 per 968 of the population. In the United States it was, according to the census of 1840, 1 per 979 or a total of 17,434 (14,508 white and 2,926 colored).

The figures do not mean much but they are interesting, nevertheless, in a comparison with the number of hospitalized patients today.

When the Association of Medical Superintendents of American Institutions for the Insane was founded in 1844, European psychiatry was still a very young medical discipline. It had, however, passed the stage of infantile diseases. The mentally sick were no longer treated as criminals or monsters but as patients suffering from diseases that were the more tragic since many of them could not be cured.

Psychiatry was well on the way toward becoming a recognized medical specialty of academic rank, with facilities for scientific research, for teaching, and for training.

¹¹ *Annales Médico-psychologiques*, I (1844), 390 ff.

THE HOUSE OF THOMAS S KIRKBRIDE



JONES HOTEL

WINFRED OVERHOLSER

THE FOUNDING AND THE FOUNDERS
OF THE ASSOCIATION

AT TEN O'CLOCK on Wednesday morning, October 16, 1844, a group of thirteen physicians, all of them superintendents of hospitals for the mentally ill, met in the Jones Hotel, a Philadelphia hostelry which then stood on Chestnut Street above 6th. Whether the Jones Hotel should properly be considered the birthplace of the Association of Medical Superintendents of American Institutions for the Insane (later the American Medico-Psychological Association, and now the American Psychiatric Association) may be a subject for argument, although unquestionably the official organization of the Association did take place there. On the evening before, however, at the invitation of Dr. Kirkbride, the group had met in the building now known as The Mansion on the grounds of the Pennsylvania Hospital, which was then the residence of the Superintendent. There they formulated some preliminary plans which were confirmed at the Jones Hotel the next day. The conception of this now lusty child had occurred the previous spring, when Dr. Woodward, on a visit to Staunton, Virginia, had discussed with Dr. Stribling the possibility of such an organization. As an upshot of that conversation, and with the encouragement of Drs. Kirkbride and Awl, arrangements were made for the meeting in Philadelphia.

The background against which this important meeting took place may be sketched briefly here; the details given in other chapters of this volume are all contributory.

In 1844 the population of the United States was estimated at 17,069,453, and the number of the mentally ill at 17,457, a ratio of 1: 977, of these mentally ill, however, only about 2,561 were in institutions. Many of them were cared for at home, many others were housed in poorhouses and jails. Much of the population of the country was concentrated in the northeastern quarter of the United States. There were then only twenty-one states and the District of Columbia; Florida, Wisconsin, and Iowa were still territories. Using the most generous interpretation of the word "institution," there were only approximately twenty mental hospitals (mostly then called asylums) in the entire country, only three of them—in Ohio, Kentucky, and Indiana—lying west of the Alleghenies. These institutions, in accord with the prevailing belief that the superintendent

should personally see every patient daily, were all small; the largest represented at the meeting of the original thirteen was that at Worcester, Massachusetts, with a total of 255 patients. Dorothea Lynde Dix was just starting on her extraordinary campaign to establish mental hospitals, a campaign which within the next forty years resulted in the organization or expansion of fully thirty institutions.

As for methods of treatment, bleeding, blistering, and purging were not yet obsolete. Only thirty-seven years before, the prospectus of the New York Hospital had gravely commented, "It is believed that proper discipline can be established among the maniacs without the use of the whip." Phrenology was generally accepted as a scientific dogma, and mental disease—or, as it was then generically referred to without much finesse of classification, "insanity"—was looked upon as due entirely to disorder of the brain, the brain being considered the "organ of the mind." With the physical basis thus conclusively assumed, much stress was laid on drug therapy, although what was known as "moral treatment" was much discussed.

All of the men who assembled at Philadelphia on that significant day, with the possible exception of Dr. Galt, had had considerable experience in the general practice of medicine. White, Awl, Brigham, and Stedman were surgeons of no mean achievement. They looked upon mental disorder, then, as something closely related to general medicine and not as something entirely set apart—a viewpoint lost for many years which is only recently beginning to be rediscovered.

These men who assembled at the Jones Hotel came, as was to be expected, from the older and more settled parts of the country. Five were born in Massachusetts, two each in Connecticut, New Hampshire, Pennsylvania, and Virginia. The oldest was Dr. Samuel White, who was sixty-seven, while Dr. Galt, the youngest, was a stripling of twenty-five. Two of them had become superintendents while in their twenties, and eight of them while in their thirties. Seven of them were under forty, and the average age was only forty-three. All of them were men of achievement and intelligence, men who were looked upon with high regard in their communities and who were motivated by a deep interest in improving the care of the mentally ill. Six were in charge of state institutions, five in charge of endowed, incorporated institutions, and two were the owners of what we today should term proprietary private hospitals.

The group voted at this meeting that "the medical superintendents of

the various incorporated or other legally constituted institutions for the insane now existing, or which may be commenced prior to the next meeting be and hereby are elected members of this Association." At the 1848 meeting this provision was broadened to provide that "trustees, managers, or official visitors of each insane asylum on this continent" should "be invited to attend the meetings of the Association." The stress, therefore, was primarily on the administration and organization of hospitals and the effect of such organization upon the care of the patients, rather than on the promotion of scientific psychiatry. This is illustrated by the list of the committees appointed at the organization meeting; the titles of these committees really constitute the agenda for the meeting, as most of these subjects were discussed during the five days: Moral Treatment of Insanity, Medical Treatment of Insanity, Restraint and Restraining Apparatus, Construction of Hospitals for the Insane, Jurisprudence of Insanity, Prevention of Suicide, Organization of Hospitals for the Insane and Manual for Attendants, Statistics of Insanity, Support of the Pauper Insane, Asylums for Idiots and Demented, Chapels and Chaplains in Insane Hospitals, Post-Mortem Examinations, Comparative Advantages of Treatment in Hospitals and in Private Practice, Asylums for Colored Persons, Proper Provisions for Insane Prisoners, Causes and Prevention of Insanity. Steps were taken to urge the institutions to record certain statistics, and a resolution was passed to the effect that "an attempt to abandon entirely the use of all means of personal restraint is not sanctioned by the true interests of the insane."

On the evening of the 20th of October, 1844, the Association adjourned to meet in Washington, D. C., in May, 1846. The officers elected at the organization meeting were Samuel B. Woodward, President; Samuel White, Vice-President; Thomas S. Kirkbride, Secretary and Treasurer.

These men and their associates bulk so large individually and collectively in the history of American psychiatry that it is only fitting that a brief biographical sketch of each be given. With the exception of the sketches of the three officers, these accounts follow in alphabetical order.

DR. SAMUEL B. WOODWARD, the first president, was one of the older men of the group who met in Philadelphia in 1844. The Association may in many ways be thought of as his "brain-child." At least, the matter was discussed while he was visiting Dr. Stribling at Staunton, Virginia, in the spring of 1844, and it was agreed that Dr. Woodward would take up the

matter further with Dr. Awl, Dr. Kirkbride, and perhaps one or two others. The outgrowth of these discussions was the organization meeting held at Philadelphia in October of 1844.

Dr. Woodward, himself the son of a physician, was born in Torrington, Connecticut, on June 10, 1787. He studied medicine with his father and was licensed to practice at the age of twenty-one. Early in his practice the difficulties of the management of the mentally ill in their own homes were impressed upon him, and with Dr. Eli Todd and a few others he was active in the establishment of the Retreat for the Insane at Hartford. Although engaged in the active practice of medicine, he still found participation in politics possible and was elected to the State Senate in Connecticut in 1830.

In 1832 Massachusetts became the first of the New England states to establish a state hospital, and Dr. Woodward was elected superintendent of the State Lunatic Hospital at Worcester. He supervised the building of the institution and remained as superintendent until his retirement because of ill health in 1846. That he was a vigorous hospital administrator may be judged from the fact that in summer he rose at 4:30 and commenced his rounds at 8:00, visiting each patient during the forenoon!

His interest in progressive methods and in the "moral" as well as medical methods of treatment is well illustrated by the concluding paragraph of his address on "The Medical Treatment of Insanity," presented before the Association in 1846 and printed in the *Journal* in July, 1850, shortly after his death:

The abandonment of depletion, external irritants, drastic purges and starvation, and the substitution of baths, narcotics, tonics, and generous diet, is not less to be appreciated in the improved condition of the insane, than the change from manacles, chains, by-locks and confining chairs, to the present system of kindness, confidence, social intercourse, labor, religious teaching, and freedom from restraint. In this age of improvement, no class of mankind have felt its influence more favorably than the insane. But we should not be satisfied with present attainments. Much undoubtedly remains to be done for them. Good influences are everywhere operating, and we may confidently hope that what is overlooked by the passing generation, which might have been beneficial to them, will be supplied by their successors.

Dr. Woodward laid much stress, as was the custom of the times, upon the role of masturbation, tobacco smoking, and alcoholic intemperance in the causation of mental disease. He was one of the early advocates of



SAMUEL B. WOODWARD

specialized medical attention for alcoholics, and in 1838 published a volume of *Essays on Asylums for Inebriates*.

Those who came in contact with Dr. Woodward were evidently much impressed by his hopeful spirit, his commanding appearance, his grace and dignity, and his great kindliness. He was interested in younger men, particularly in promoting their interest in medicine, he was largely responsible, for example, for directing Dr. John S. Butler into the field of psychiatry, a field which the latter did much to ornament. Dr. Woodward retired from the presidency of the Association in 1848, two years after he had left Worcester to reside in Northampton, Massachusetts. He died there suddenly on January 3, 1850.

SAMUEL WHITE was, in years, the senior of the entire group of the founders of the Association. He was born in Coventry, Connecticut, on February 23, 1777. It appears likely that he never attended medical school but followed the apprentice system which was in vogue in his time. In 1797, when only twenty years of age, he opened his office for the practice of medicine at Hudson, New York, and soon achieved considerable fame as a surgeon, partly as the result of a successful enterostomy for the extraction of a teaspoon. He served for two years as professor of obstetrics and surgery in the short-lived Berkshire Medical Institution at Pittsfield, Massachusetts.

In 1830 he established a private institution under the name of the Hudson Lunatic Asylum, which he operated successfully until the time of his death. He and Dr. Nehemiah Cutter were the only physicians connected with proprietary institutions who were admitted to the sacred circle of the Original Thirteen—a tribute to the standing of the men and their institutions. Dr. White was elected vice-president of the Association at the initial meeting and at that time was appointed to four committees.

The only published work known to be extant is his address on insanity given on February 5, 1844, as president of the New York State Medical Society. The address, though only twenty pages long, well presents the views on mental disorder which were generally accepted at that time. Dr. White advocated the study of the entire man wrought upon by external causes, and attributed mental disorder largely to an irritation acting specifically on the brain and the nervous system, and sympathetically on the vascular system. He remarked that the sudden suppression

of eruptions was likely—by reason of the close sympathy between the brain and the skin—to produce mental symptoms, and scrofula he considered a fruitful source of insanity. Puerperal insanity was due to a metastasis of the morbid lacteal and lochial secretions. Venesection was frowned upon; instead, a warm bath of twenty to thirty minutes with cold to the head was recommended, as were a number of narcotics, including opium, belladonna, and aconite. Conolly's work on nonrestraint was favorably mentioned, and Dr. White urged that no more restraint than was "absolutely necessary" for the patient's and others' safety be utilized.

Unfortunately, Samuel White was able to attend only the opening meeting. His health began to fail soon after, and he died at his home in Hudson, New York, on February 10, 1845.

The name of THOMAS S. KIRKBRIDE has probably achieved a wider fame than that of any other of the Original Thirteen. From 1847, the time of the appearance of his first article on "Hospital Construction," to the end of the nineteenth century, the "Kirkbride type" of hospital construction was a prevalent one in mental institutions the country over.

Dr. Kirkbride was born near Morrisville, in Bucks County, Pennsylvania, July 31, 1809, a descendant of members of the Society of Friends who accompanied William Penn in his first settlement of the Province of Pennsylvania. He studied medicine with a physician who had come from France under Lafayette during the American Revolution, and later studied at the University of Pennsylvania, receiving his degree of Doctor of Medicine in March, 1832. He served a year as the resident physician at the Friends' Asylum, and the following year was elected resident physician at the Pennsylvania Hospital. For a time he practiced surgery in Philadelphia, until appointed physician-in-chief and superintendent of the new Pennsylvania Hospital for the insane, a post in which he served with distinction for a period of forty-three years.

Dr. Kirkbride was, in an intimate sense, one of the founders of the Association. He was consulted by Drs. Stribling and Woodward in the spring of 1844 concerning the desirability of establishing an association, took an active part in the organization meeting, and was elected the first secretary of the Association. The degree of his participation in Association affairs is indicated by the fact that he served as secretary for eight years, then as vice-president for seven years, 1855 to 1862, and as president

for eight years, 1862 to 1870. At the first meeting his interest in organizing hospitals for the insane and in founding a manual for attendants was indicated by his appointment as chairman of the committee dealing with those matters. He was an active participant in the affairs of the Association throughout his life, and contributed a number of articles to the *American Journal of Insanity*, as well as to the *American Journal of Medical Sciences*.

In 1854 Dr. Kirkbride published a volume on the construction, organization, and general arrangements of hospitals for the insane, a volume which was expanded fourfold in its second edition in 1880. He advocated as the most economical form of construction a center building with wings on each side, "so arranged as to give ample accommodations for the resident officers and their families, and for the classification and comfort of the patients." His treatment of the details shows the thoroughness of the man and the profound attention that he gave to various factors, not only of physical construction, but of organization and care and comfort of the patients. He was the author of the "Propositions on the Organization of Hospitals for the Insane," which was adopted by the Association at the meeting held in 1853. In accord with the practice of the times, Dr. Kirkbride advocated that the chief medical officer should see each patient every day, and that the proper number of patients in such an institution should not exceed two hundred and fifty. He believed that if more patients than this needed to be accommodated, the state should set up another institution in another locality to cut down the necessity of travel by the relatives. He urged cheerful and comfortable appearance of the exterior of the building, as well as of the interior, and emphasized in everything he wrote about construction the necessity of suitable classification. There should not be, he said, less than eight classes of wards for each sex.

The name of Kirkbride is associated so inseparably with the construction of mental hospitals that it is often not realized that he was at the same time actively interested in the care of patients. As early as 1841 he established books of rules for attendants, and he was an early advocate of minimal restraint, although not a partisan of the English nonrestraint school. In 1843 he instituted a hospital newspaper. The next year he advocated and planned excursions for his patients; he arranged a series of lectures for them, a plan which was followed later on by a number of other institutions. Magic lantern entertainments and lectures were given

under his direction by his indefatigable assistant Dr. Curwen, later to become one of his successors as secretary and president of the Association. He was an earnest advocate of the employment of patients, as well as of their amusement, and took much interest in the improvement of the grounds and the development of the surrounding farm. The supervision of outdoor affairs he looked upon as excellent relaxation for a superintendent, and he followed this precept himself in overseeing personally the building of the Department for Males of the Pennsylvania Hospital for the Insane, much of the money for which he raised.

Dr. Kirkbride's interest in psychiatric instruction is illustrated by a resolution which he presented before the Association at the 1871 meeting, urging that

"in view of the frequency of mental disorders among all classes and descriptions of people, and in recognition of the fact that the first care of nearly all these cases necessarily devolves upon physicians engaged in general practice . . . in every school conferring medical degrees, there should be delivered by competent professors a complete course of lectures on insanity and on medical jurisprudence as connected with the disorders of the mind."

The resolution also urged that these lectures should be compulsory and that they should be accompanied by clinical instruction.

Dr. Kirkbride took an active part in various other community activities; he was a trustee of the Pennsylvania Institution for the Blind for over forty years, and was a trustee of the Harrisburg State Lunatic Hospital from 1859 to 1862. His advice on hospital construction was sought the country over, but what undoubtedly meant the most to him was the devotion of his patients.

He died on December 17, 1883, at the institution which for over forty years had been his home.

WILLIAM MACLAY AWL was born in Harrisburg, Pennsylvania, on May 24, 1799, a descendant of the founder of the city. He was another product of the apprentice system, although there is a record that he attended one course of lectures in the years 1819-20 at the University of Pennsylvania. He later received the honorary degree of Doctor of Medicine from Jefferson College.

The West was beckoning, and in 1826 Dr. Awl began the long journey to Ohio on foot. He practiced in several cities, finally settling in Columbus in 1833. The lack of facilities for the care of the mentally ill struck

him forcefully, and with a group of others he was active in securing authorization from the Legislature to erect a hospital; he was one of the trustees commissioned to supervise its construction. In 1838 he resigned as trustee and was appointed superintendent. His standing among his fellow superintendents is attested by the fact that he and Dr. Kirkbride were the two superintendents named by Dr. Stribling as men to be consulted by him or Dr. Woodward before the organization meeting of the Association was to be called.

At the meeting of the Association in 1846 Dr. Awl was elected vice-president, and in 1848 president, continuing in that office until his resignation in 1851. In 1850 he was, in the words of Dr. Curwen (writing in 1894), "displaced by that system of political appointment which has so unfortunately prevailed in Ohio from that day to this" (There were, in fact, four superintendents of the State Hospital at Columbus during the six years following Dr. Awl's forced resignation in 1850!)

He has been described as a man of great force of character, of originality, of knowledge of the world, a man who had a choice sense of humor and sound common sense. It is likely that he wrote nothing (except for his annual reports) on the subject of mental disorder. In 1827 he reported a difficult surgical operation (removal of a tumor, with ligation of the left carotid artery) which he had performed, and he is said to have left a number of manuscripts, some on Biblical subjects. He was active in the organization of the Ohio State Medical Society.

After his resignation from the superintendency Dr. Awl returned to private practice. He died on November 19, 1876.

LUTHER V. BELL, the distinguished son of a distinguished family, was born in Francestown, New Hampshire, on December 30, 1806. His great-grandfather was a state senator in New Hampshire; his father was a member of both houses of the State Legislature, and became a governor's councillor, Governor, and later United States Senator. One of his brothers was a chief justice of New Hampshire. Dr. Bell himself was evidently a rather precocious youth, for he entered Bowdoin in 1819, when he was just under thirteen years of age. While there he knew Franklin Pierce, Nathaniel Hawthorne, and Henry W. Longfellow. He then attended Dartmouth, receiving the degree of Doctor of Medicine in 1826. For six years he practiced medicine in Derry, New Hampshire, finding time in the interval to serve in the State Legislature and to take an

active part in establishing the State Asylum at Concord. In 1834 he received the Boylston Medical Prize, then awarded annually in Boston.

In 1837 he was unexpectedly notified of his election as superintendent of the McLean Asylum in Somerville, an institution then nineteen years old and housing seventy patients. This post he filled with distinction and honor for nineteen years, resigning because of ill health in 1856. In 1840 he visited a number of institutions in Europe, reporting on them in the annual report of the hospital for 1841, and again in 1845 he traveled to Europe to make further studies for the trustees of the Butler Hospital in Providence, which was then being planned.

A review of Dr. Bell's bibliography indicates the wide range of his medical interests. One finds discussions of smallpox, diet for laborers, heating and ventilating, coercive administration of food to the insane, and a form of disease "resembling advanced stages of mania and fever" (long referred to as Bell's Disease); one finds also a volume of medical opinion in the Parish will case, one of the famous cases of the times, in which he testified as an expert.

Dr. Bell was an active participant in the meetings of the Association; he served as vice-president from 1850 to 1851, and as president from 1851 to 1855. He was also president of the Massachusetts Medical Society in 1857. He was interested particularly in the medical aspects of mental disease and was progressive in matters of treatment. Although favoring a minimum of restraint, he was opposed to the doctrine of complete nonrestraint; in fact, in one of his reports he suggests that some of the supposed nonrestraint practices at Hanwell, England, savor strongly of mechanical interference. He was much in demand as an expert witness in court.

Besides all these activities, he found time to serve as chairman of the School Committee of Somerville, member of the Governor's Council of Massachusetts in 1850, and delegate to the Whig Convention in 1852. Some criticism was voiced by his colleagues because of his alleged interest in spiritualism. As a matter of fact, at that time about three million fellow Americans were actively interested in this doctrine, and Dr. Bell properly felt that he should investigate scientifically a topic which had an appeal to so many persons. He was awarded the honorary degree of Doctor of Civil Laws in 1847, by Kings College in Nova Scotia, and of Doctor of Laws by Amherst College in 1855. In 1856 he resigned his position of superintendent because of ill health, retiring to Charlestown where he continued to do a consultation and court practice. He was one of the commit-

tee appointed to superintend the building of the Northampton State Hospital. His attitude toward the duties of a superintendent is well summed up in the statement, "The less wise or reasonable the subjects of any man's oversight or sympathy, the more wise and reasonable must he be in order to discharge his trust."

His perspicacity in medico-legal affairs is well illustrated by his pungent criticism of the McNaghten case and the tests of responsibility, a criticism which appeared in his annual report of the McLean Asylum for 1844: "It is obvious that the earliest opinions were formed without much reference to the actual facts; they appear rather to have been the ingenious closet speculations of scholars over works of an ancient metaphysics than of practical observers."

At the outbreak of the Civil War Dr. Bell volunteered his services and was appointed surgeon of the 11th Massachusetts Regiment on June 10, 1861. He was subsequently promoted to the position of medical director of General Hooker's division. It was while carrying out his duties in this post that he died suddenly in camp near Washington, D. C., on February 11, 1862, the only one of the Original Thirteen to have served in the Civil War.

AMARIAH BRIGHAM was a native of New Marlboro, one of the small hill towns in the southwestern part of Massachusetts, where he was born on December 26, 1798. He studied medicine with physicians in New Marlboro and in Canaan, Connecticut, and in 1821 began to practice in Enfield. Shortly afterward he moved to Greenfield, Massachusetts, where he practiced for about seven years. In 1828 he went to Europe, where he spent a year traveling, visiting hospitals, and attending medical lectures. He returned to Greenfield for a time and then in 1831 moved to Hartford, Connecticut. During all of this time he was practicing medicine and surgery, but just when his interests turned to psychiatry is not clear. It must have been before he went to Hartford, for in 1833—two years after his arrival in that city—he published an appendix to Spurzheim's volume entitled *Observations on the Deranged Manifestations of the Mind, or Insanity*.

This period of Dr. Brigham's life was a productive one. In addition to the appendix already mentioned, he published a book entitled *Remarks on the Influence of Mental Cultivation upon Health*, which had an astonishing sale. It was published in Edinburgh in 1835 and in Glas-

gow in 1836; there was also a later London edition. The object of this volume was, in the words of the author, "to show the necessity of giving more attention to the health and growth of the body and less to the cultivation of the mind, especially in early life, than is now given." He cautioned against the influence of mental cultivation in the production of dyspepsia and advocated mental relaxation and more physical exercise. This work was apparently influenced by the teachings of Gall and Spurzheim. Brigham speaks of the knowing and reflecting "faculties" and says that each "faculty" has a separate and material instrument or organ in the brain.

During this period he also wrote a treatise on epidemic cholera (1832), *Observations on the Influence of Religion on the Health and Physical Welfare* (1835), and in 1840, while still in Hartford, an *Inquiry Concerning the Diseases and Functions of the Brain, Spinal Cord and Nerves*. Dr. Brigham's recognition of the psychosomatic point of view is illustrated by his comment in this work: "The influence of mind—of mental emotion, in causing and curing disease [is] altogether too much disregarded by medical men."

In 1837 Amariah Brigham was appointed lecturer in anatomy at the College of Physicians and Surgeons in New York City, but he returned to Hartford a year and a half later. In 1840 he was elected superintendent and physician of the Retreat for the Insane in that city.

Two years later, however, in the fall of 1842, he was appointed superintendent of the State Lunatic Asylum at Utica, the first state institution authorized by the State of New York. During Dr. Brigham's administration the asylum became known as a training place for superintendents; a number of men who subsequently achieved considerable eminence served on the staff under him. His administration of the hospital was decidedly a progressive one. He had workshops and an academic school, taught penmanship and singing to the patients, had tableaux and dramatic exhibitions, and "conversaziones." Dr. McFarland, in his reminiscences in 1878, said that under Dr. Brigham "no means were unthought of and untried." Dr. Brigham was elected vice-president of the Association in 1848, his health for a year or so had been rather precarious, however, and he died the following year, September 8, 1849.

Distinguished author and hospital administrator as he was, Amariah Brigham finds his most cherished place in the minds of American psychiatrists as the founder of the *American Journal of Insanity*, now known

as the *American Journal of Psychiatry*. The first issue of the first volume appeared in July, 1844, four months before the organization meeting of the Association. This issue was the unaided work of Dr. Brigham; it contained six articles and a number of miscellaneous comments, including, incidentally, a notice of the establishment of the new *Annales Médico-psychologiques* in Paris. The *Journal*, then published quarterly, was designed "to acquaint the general reader with the nature and varieties of this disease [insanity], methods of prevention and cure." "We also hope," continued the Prospectus, "to make it interesting to members of the medical and legal profession, and to all those engaged in the study of the phenomena of mind." Subsequent numbers of the first volume contained articles by John M. Galt, Pliny Earle, and Samuel B. Woodward, among others.

Dr. Brigham was a clear writer, a sound scholar, and an indefatigable and progressive administrator. Although he died at an early age, he left an indelible imprint upon the development of psychiatric literature in the United States, and is deserving of the high place which he occupies in the hall of psychiatric fame. "By his systematic writing," says McFarland, "he prepared the public for an awakening to the claims of the insane."

JOHN S. BUTLER was born in Northampton, Massachusetts, in 1803. He studied medicine with two of the local physicians, attended some lectures at the Harvard Medical School, and finally received his degree of Doctor of Medicine from the Jefferson Medical College in Philadelphia in 1828. He then set up practice in Worcester, remaining there for ten years. During this period he showed a diagnostic acumen which, in spite of the opposition of some of the older physicians, inspired a great deal of confidence among his patients. He was very fortunate in early establishing a close relationship with Dr. Samuel B. Woodward, then superintendent of the State Lunatic Hospital at Worcester. He was very friendly with Dr. Woodward, frequently visiting the hospital and spending much time on the wards. His interest in the subject of mental disorder, and his great aptitude in dealing with patients, made such an impression that when the superintendency of the Boston Lunatic Hospital became vacant in 1839, Dr. Woodward urged, and to a large extent brought about, Dr. Butler's appointment to the position.

Because of its previous management the hospital had suffered some-

what in public esteem, but Dr. Butler soon brought about a new attitude among the patients and employees; his work is very vividly and favorably described by Dickens in his *American Notes*. Dr. Butler practically abolished seclusion and restraint, developed occupation, organized dances, and took part in the activities of the patients. Unfortunately the pressure of politics soon became unpleasant at this institution (as has been the case there even more recently!), with the result that in 1842 Dr. Butler resigned, intending to enter practice in Boston. About this time, however, Dr. Brigham left the Hartford Retreat to go to Utica, New York, and in 1843 Dr. Butler was elected his successor, remaining at Hartford until he retired in 1872. His administration of the Retreat was likewise distinguished from the medical and humanitarian points of view; under his vigorous leadership it continued to develop and to maintain its position in the vanguard of American mental hospitals.

Dr. Butler was a regular attendant at the meetings of the Association; he served as vice-president from 1862 to 1870, and as president from 1870 to 1873. He was an honorary member of the Medico-Psychological Association of Great Britain.

He was evidently a man of great warmth, charity, and optimism, one who was fond of younger men and who, as a result, always stayed young himself in spirit. He was not a prolific writer, and aside from his annual reports only two volumes are extant. One of these, *The Curability of Insanity* (1887), interestingly enough appeared in the same year as a volume of identical title by Pliny Earle. This book was largely devoted to the thesis that "strictly recent insanity in very many cases is radically curable under the prompt, persistent, and united use of medical and moral means." As a corollary, Dr. Butler held that separate institutions should be established for the chronic insane, whose presence, he believed, retarded progress of the acute cases. This stand was directly in opposition to the official promulgations of the Association on this point, and it may be added that his doctrine has never been widely approved. He spoke of what he termed "individualized treatment," defining this as "the influence of a sane addressed to an insane mind." He was a great believer, too, in the importance of the superintendent's daily visit to his patients; he held that this was one of the most important of the superintendent's duties. He looked upon the want of physical stamina as the important cause of mental disease, and stressed the point that since insanity is

"strictly a physical disease," it comes "eminently within the range of preventive medicine."

Dr. Butler's address on "State Preventive Medicine" (1879) was perhaps the first proposal by a public health official that mental disorder be recognized as an integral part of the field of preventive medicine. Almost prophetically he said in his address:

We can also more efficiently apply the means of its [insanity's] prevention and remedy, when we can better measure its varied pernicious causes, such as erroneous educational and social influences, neglect of family training to reverence and obedience, sensational reading, evil habits of body and mind, and idle, aimless, or sensual lives, and learn more exactly as we shall surely learn, how very early in life the predisposing causes of insanity are planted in the child

John Butler retired from the superintendency of the Retreat in 1872, but it was not to be expected that a man of his energy and broad medical interests would content himself with *otium cum dignitate*. He continued to interest himself in various medical activities and became the President of the first State Board of Health in Connecticut. He died at Hartford on May 21, 1890.

NEHEMIAH CUTTER was one of the seniors of the group. Born in Jaffrey, New Hampshire, on March 30, 1787, he graduated from Middlebury College in 1814 and received the degree of Doctor of Medicine from Yale in 1817. Soon after his graduation he went to Pepperell, Massachusetts, where he entered the practice of medicine.

Almost immediately he had occasion to care for a patient suffering from a mental disorder, and as early as 1822 he was receiving mental patients into his family. In 1834 he built a larger building and increased the number of patients, his establishment being generally known from that time on as the Pepperell Private Asylum. As has already been mentioned, Samuel White and Nehemiah Cutter were the only two of the Original Thirteen who were associated with a private proprietary institution, a type of institution which in those days was looked upon with some degree of suspicion. It is recorded in the obituary notice printed in the *American Journal of Insanity* at the time of Dr. Cutter's death that "he maintained the reputation of his institution unimpaired in spite of the prejudice against private asylums."

Nehemiah Cutter was evidently a man of high character and great

public spirit, one who readily accepted improvements in the care of mental disorders, and who took a great interest in the affairs of the Association. He was a member of the Committee on the Moral Treatment of Insanity, appointed at the founding meeting in 1844; in 1848 at the Washington meeting he reported for a committee on "The Effects on the Insane of the Use of Tobacco." No extant publications are known.

Dr. Cutter attended almost every meeting of the Association that was held from 1844 until the time of his death.

In 1853 his institution was burned to the ground. Dr. Curwen comments, "Nothing daunted, however, he assumed immediately the long laid aside duties of common professional life and won as a practicing physician, when close upon three score and ten, the fresh confidence of the community in which he lived and died." His death occurred on March 15, 1859.

One of the most vigorous members of this group of thirteen remarkable men was **PLINY EARLE**. Only thirty-five years of age at the time of the founding of the Association, he outlived all of his twelve fellow founders and probably contributed more to the literature of mental disorder than any of his colleagues with the one exception of Isaac Ray.

Dr. Earle was born in Leicester, Massachusetts, December 31, 1809, a descendant of a Quaker family which maintained a consistent interest in the antislavery movement. He attended the Leicester Academy and the Friends School at Providence, Rhode Island, and taught school for several years; one of his pupils—Charles H. Nichols—was later to become president of the Association. Dr. Earle then entered upon the study of medicine, graduating from the University of Pennsylvania with the degree of Doctor of Medicine in 1837. His interest is said to have been drawn early to the subject of mental disorder by reason of the fact that a cousin died as a patient in a mental hospital; at any rate, he wrote his doctoral thesis on the subject of insanity. Upon graduation he went to Europe, remaining there for nearly two years. He saw the coronation of Queen Victoria, saw Lister operate, talked with Samuel Tuke, met the younger Pinel, Ferrus, and Esquirol in Paris, and visited institutions in several of the European countries.

Upon his return Dr. Earle opened an office for the practice of medicine in Philadelphia, and for a time he served on the staff of the Frankford Retreat. At that time bleeding was still in vogue, as were blistering and

cupping, the tranquilizing chair, muffs, and wristlets were in use. Dr. Earle was opposed to these practices, just as he was opposed to the use of the douche as punishment when he saw it so used in Paris.

In 1844 he was appointed superintendent of the Bloomingdale Asylum in New York; he remained there for five years, resigning because of ill health. He took this opportunity to go to Europe again and spent a considerable period touring Germany and visiting German institutions. At that time very little was known in this country of the German practices, and in his subsequent writings Dr. Earle presented much of what was best in German psychiatry.

On his return he lived for nearly fifteen years in his native village, consulting and writing and attending to family affairs. During the Civil War he spent two winters at the Government Hospital for the Insane in Washington, assisting his friend Dr. Nichols in the care of the large number of patients received as a result of the conflict. In the interval he was also appointed professor of psychological medicine at the Berkshire Medical Institution in Pittsfield, Massachusetts (1863). This was probably the first time in the United States that a chair of this sort had been established in a medical school, and that mental disorder had been recognized as a necessary part of medical studies.

From 1864 to 1885 Dr. Earle served as superintendent of the State Lunatic Hospital at Northampton, Massachusetts. He retired in the latter year, but lived at the Institution until his death on May 17, 1892.

Pliny Earle was recognized as an outstanding hospital administrator, but his fame rests securely upon his many and varied contributions to psychiatric literature, particularly with reference to the statistics of mental disorder. From 1838 when he wrote his doctoral thesis until literally the year of his death, 1892, hardly a year passed without several contributions from his pen. Many of these were reviews of reports on the mental hospitals of the United States and on various European institutions. He wrote a number of historical essays, published at least two volumes of poems, wrote the chapter on "Insanity" in the United States Census for 1860, and at least one essay on the practice of blood letting in mental disorders.

His most important contribution, however, was in the field of statistics. In 1877 he published a volume, later amplified (1887), under the title, *The Curability of Insanity*. He had a mathematical mind and certainly the courage of his own convictions, for he indicated very clearly the errors

in the claims made by some of his colleagues such as Drs. Galt, Awl, and the great Ray himself. Dr. Earle lived in the early days of what Deutsch has called the "cult of curability." With good humor but with inescapable logic, Earle traced the history of what he termed the "curability delusion." He showed how the hopes of his colleagues had outrun their statistical judgment, and emphasized particularly the importance of indicating which of the admissions were first admissions and of distinguishing between cases and persons. He devised the statistical tables for the State Board of Charities in Massachusetts, and expressed the hope that eventually the Association would perfect its statistical system so as to approach that of Massachusetts and of the British Medico-Psychological Association. Indeed, in one of his earliest articles, written in 1838, he remarked, "If a common formula for the statistical part of the reports could be adopted by all the asylums . . . our knowledge would be more rapidly advanced."

Many of Dr. Earle's articles bear titles which sound startlingly modern. In 1868, for example, he published his inaugural lecture at the Berkshire Medical Institution, which was entitled "Psychological Medicine—Its Importance as a Part of the Medical Curriculum." In it, he quoted Grotius as having said two hundred years before, "The care of the human mind is the most noble branch of medicine," but referring to the whip, restraint, and jailers he remarked that "hardly anyone had agreed with that statement." He then went on to say, in his picturesque and humorous manner, that "ferruginous preparations were everywhere about the patient; but being applied externally they acted as a tonic or strengthener to the turn-key physician rather than to the unfortunate person under his care."

Again, in 1867, at the laying of the cornerstone of the Hospital at Middletown, Connecticut, he read an address entitled, "The Psychopathic Hospital of the Future." He commented that the curative power of moral treatment had not yet been learned, that a hospital should have its curriculum and a regular course of exercises for the patients. He spoke of the effect of public opinion which acted as an obstacle to the perfecting of institutions. The desiderata of a perfect mental hospital he named as a comprehensive curriculum, complete organization, perfect systematization, and efficient administration. He advocated small hospitals aimed at cure, separate asylums for the incurable, and family care. The state should care for the mentally ill, he said, and not the county



FRANCIS T. STRIBLING

or the city. He was opposed to elaborate institutions, and his remarks concerning the expensiveness of the construction of one of the later state hospitals in Massachusetts must have been taken as scathing indeed by his colleagues there.

Dr. Earle was a long and consistent advocate of occupation and was most emphatic in his deprecation of anything savoring of deceit of the patient. He was a lifelong friend, admirer, and adviser of Dorothea Lynde Dix. He took justifiable pride in the fact that he was one of the organizers, not only of the Association, but of the American Medical Association and of the New York Academy of Medicine. In our own Association he served as vice-president from 1883-1884, and as president from 1884-1885. He was for forty-eight years an honorary member of the Medico-Psychological Association of Great Britain. In the New York Academy of Medicine he was a Resident Fellow, along with such other outstanding men as Valentine Mott, Willard Parker, and J. Marion Sims. The first article in Volume I of the *Transactions* of the New York Academy of Medicine, published in 1857, was by Dr. Earle: "Historical Sketch of the Institutions for the Insane in the United States of America." He contributed no fewer than fifteen original papers to the *American Journal of the Medical Sciences*. He was consulted by Amariah Brigham concerning the founding of the *American Journal of Insanity*, and contributed an article on "The Poetry of Insanity" to the third number of Volume I of the *Journal* (January, 1845).

A man of profound scholarship and keen human interest, a forceful writer and advocate of progress in the field of psychiatry, Pliny Earle is properly referred to by his biographer, Frank B. Sanborn, as the Nestor of American alienists.

JOHN MINSON GALT was, by comparison with the rest of that group at Philadelphia, a mere youth. Born on March 19, 1819, he had, at the age of twenty-two, become the first superintendent of the Williamsburg Asylum, an institution with which his father and grandfather had been associated as physicians, and of which his great uncle had been the first keeper. Born in Williamsburg, he attended the College of William and Mary, where he received the A.B. degree in 1838. He then proceeded to Philadelphia and received the degree of M.D. from the University of Pennsylvania in 1841.

Galt was perhaps, in the classical sense at least, the most scholarly of

the Original Thirteen. He read Thucydides in the original for pleasure, was familiar with practically all of the European languages (with the exception of Russian and Turkish), was able to read the Koran in the original Arabic, was a botanist of ability, and an avid reader of the foreign literature on mental disease. He is said to have been of athletic tastes as well—a strange combination in those days! In 1846 he published a volume entitled *The Treatment of Insanity*, presenting abstracts of the views of about seventy-five contemporaries in England, France, and Germany. The book is a valuable summary of the literature then available on the subject of mental disease. Galt was, of course, familiar with the American writings on the subject, and particularly hailed the works of Isaac Ray for their clarity and progressiveness.

Galt was a true progressive; he was a man of forward vision, and one who recognized the need and value of change. He was much interested in what was then known as moral treatment, in his administration of the Williamsburg Asylum he used occupation, recreation, bibliotherapy, and musical therapy. He well summarized the purpose of these forms of therapy as being "to prevent the insane from lapsing into the dull torpor of reveries and indolence into which it is the very nature of man to sink if mind and body alike are left in a state of vacuity from the want of means to occupy them." At the Asylum he introduced school classes as well, following the example of Kirkbride at Philadelphia in this regard. He favored a minimum of restraint, insisted on the proper keeping of records, believed that a hospital should be a place of research, and encouraged the performing of autopsies. He was much interested in the legal aspects of psychiatry, and in his annual reports he pointed out the unrealistic nature of the law's tests of criminal responsibility.

Galt was a fairly voluminous writer. In addition to *The Treatment of Insanity*, he was the author of at least two other volumes and edited an issue of a treatise on *Practical Medicine*, written by his father. He wrote an article entitled "Fragments of Insanity" for the first volume of the *American Journal of Insanity*, and was a frequent contributor to the *Journal*. Throughout his life he contributed articles to magazines on general subjects, as might well be expected of a man of his wide literary tastes. He brought to the administration of the Williamsburg Asylum the knowledge of the best of that period, and operated the institution in a progressive and able manner.

On May 6, 1862, the Federal troops occupied Williamsburg and took

over the Asylum. Dr. Galt died on May 18 of that year, very likely of angina, only a few days after the Federal troops had refused him permission to enter the grounds of the institution which was so dear to him.

One of the most remarkable of these men, if not the giant among them all, was ISAAC RAY. Difficult as it is to choose among so eminent a group, the opinion may still be ventured that Ray stands out as the most prolific writer, the most original, and the most forceful of all the thirteen founders.

Ray was born in Beverly, Massachusetts, on January 16, 1807. He attended Phillips Andover Academy and Bowdoin College, but his health did not permit him to graduate from the latter institution. He then studied medicine in the office of a local physician, and also under Dr. Shattuck of Boston, finally graduating from Harvard Medical School in 1827. He opened an office in Portland, Maine, and practiced there for a time, during the same period teaching botany and even writing *Conversations on the Animal Economy, Designed for the Instruction of Youth*. He interrupted his practice to spend almost a year in England and France (1828-1829).¹

Ray devoted several months in Paris to attending lectures at the School of Medicine and at the Sorbonne. He saw Dupuytren and Roux operate at the Hôtel Dieu, heard Guizot lecture on history at the Sorbonne, and saw the great Cuvier at the Academy of Sciences. His descriptions of the operations which he saw emphasize to us how far surgery has progressed since that day. Some of his side comments, however, cast great light upon the activity of Ray's mind, his keen interest in humanity, and his powers of observation. He speaks of attending a performance of Rossini's opera *Otello* and remarks, "I was surprised to see so many old men, many white beards, say 60 to 80 years old, and many more if they took off their wigs. I think the French take all proper means to appear young by dress—wigs—and frequenting gay places, etc., so that an old man often passes for youngish—and all this I like." His comments on

¹ We are fortunate in that new light on this period of Dr. Ray's life has recently been shed by the discovery at the Butler Hospital of a highly detailed diary which Dr. Ray kept of this trip to Europe. The diary has not yet been published but has kindly been made available to me by Dr. Arthur H. Ruggles, the present superintendent of Butler Hospital. It is to be hoped that some day arrangements can be made to publish it, for it is an extremely interesting document concerning the European scene in 1828 as viewed through the eyes of a young and intelligent physician.

the group of dignitaries whom he saw at the Academy of Sciences are likewise enlightening, particularly if we remember the interest in the doctrines of phrenology which was then current. He says,

Indeed I should say that here the doctrine of temperaments and craniology must be put to flight, for there are forms and heads of all kinds and all equally great men I should say one-third are very large fleshy men, one-third very tall and very slim men, and one-third small and short, below middle size And I noticed some singular foreheads, exceedingly retreating A distinguished engineer has a retreating forehead [but] high back part Cuvier has a very large head, while others have small

Ray evidently enjoyed Paris very much. He remarks,

Never hear coughing here in church and lectures as with us What is cause? The atmosphere is here always humid and pavements wet I think the lower order of people here look more happy or i e , more free from care and disease and with bloat than with us Here all the cartmen and pedlars look healthy and temperate, happy and laughing In U S and England they look sorry or swaggering or bloated and drunk. Here all have enjoyments such as the spectacles which take place of drinking.

After this European trip Ray returned to Portland, Maine, but shortly thereafter moved to Eastport, in the same state. He became interested in the legal aspects of mental disorder, and in 1838 published his *Medical Jurisprudence of Insanity*. Aside from Thomas Cooper's tracts on medical jurisprudence in 1819 and a chapter in Theodric Romeyn Beck's *Elements of Medical Jurisprudence* (1823), this volume of Ray's was the first treatment of the problem in the United States. The book went through six editions. In 1856 John Minson Galt, writing in the *Journal of Insanity*, said that "it does more credit to America than aught in relation to insanity that has been produced." Galt remarked further in speaking of Ray's writings in general that they were clearer than those of any writer except Esquirol.

In 1841 Dr. Ray became medical superintendent of the State Hospital for the Insane at Augusta, Maine, a post which he held until he was called by the Board of Trustees of the Butler Hospital in Providence to become superintendent of that institution, which was then about to be organized. At the request of the Trustees he again traveled to Europe in 1845, visiting a number of institutions for mental disease, and returned to superintend the construction of the hospital, which was opened in 1847.

Ray remained at that institution for twenty years, showing himself to be an able and progressive administrator. When his health became impaired he resigned and moved to Philadelphia, where he engaged in literary work, matters of public interest, and to some extent in consultation practice. He was given an honorary degree of Doctor of Laws by Brown University in 1879, was vice-president of the Association from 1851 to 1855, and president from 1855 to 1859. He died in Philadelphia on March 31, 1881.

A glance at the bibliography of Isaac Ray causes one to marvel that a man so busy with hospital activities should have been able to produce such an enormous amount of original work. From 1828 until 1880 only one year passed without one or more volumes or original articles from his fertile pen. He was a frequent contributor to the *American Journal of Insanity*. He also wrote in such magazines as the *Law Reporter*, the *American Jurist*, the *American Journal of Medical Sciences*, the *American Quarterly Review*, and the *North American Review*. Many of his articles reflected his absorbing interest in the legal aspects of mental disease. His "Project of a Law," adopted by the Association in 1868, outlined very clearly the medically desirable attitudes of the law toward the mentally ill. The same field is discussed in the majority of the essays collected in his *Contributions to Mental Pathology* (1873). In one of these essays—an article which is as timely today as when it was written seventy years ago—he considers the matter of medical experts, and concludes: "We must look for improvement, not so much to any devices of legislation as to broader views and a firmer spirit on the part of those who administer the laws, to a higher sense of professional honor, both in the lawyer and in the physician, and to a healthier public sentiment."

Those who are inclined to look upon the term "mental hygiene" as one of recent coinage will be interested to know that in 1863 Dr. Ray published a volume of 338 pages bearing this title. Mental hygiene he defines as "the art of preserving the health of the mind against all the incidents and influences calculated to deteriorate its qualities, impair its energies, or derange its movements." It must include then, he says, the management of the bodily powers, the laws of breeding, the government of the passions, a sympathy with current emotions and opinions, and a discipline of the intellect. He urges that if a patient is sent to a hospital the family should by all means give the hospital a fair trial. He points out that every advance in civilization implies additional cerebral effort,

and that for this reason attention to the subject of mental hygiene is progressively more important; particularly (a modern note indeed!) is attention needed because of the failing influence of the home in education.

A man of broad interests, of rich humanity, and of vigorous mind, Isaac Ray is indeed one of the bright stars of the psychiatric firmament.

CHARLES H. STEDMAN was born in Lancaster, Massachusetts, on June 17, 1805. He attended Yale College but did not graduate, although subsequently he received the honorary degree of Master of Arts. He was graduated from the Harvard Medical School in 1828 and two years later was appointed resident surgeon at the United States Marine Hospital at Chelsea. During the ten years in which he held this position he evinced great interest in the work of Gall and Spurzheim. In 1834 he edited a translation of Spurzheim's work on the anatomy of the brain, a translation which proved sufficiently popular to call for a second edition in 1836. Stedman had evidently come in fairly close touch with Spurzheim during the latter's stay in Boston and had, himself, followed with considerable interest in the autopsy room the developments in the field of neuroanatomy.

In 1840 Dr. Stedman entered practice in Boston. Two years later, upon the resignation of John S. Butler, he was appointed superintendent of the Boston Lunatic Hospital, and physician and surgeon to the various other city institutions which lay in the immediate vicinity. At the time of the organization of the Association Dr. Stedman served on four committees: Restraint, Jurisprudence, Chaplains, and Post-mortems. Unfortunately, however, he never contributed any articles to the *American Journal of Insanity*; although he was possessed of literary gifts he disliked to write.

He was progressive and studious, and his administration of the Boston Lunatic Hospital was in line with the best traditions established by his predecessor, Dr. Butler. Dr. Stedman resigned in 1851, returning to practice in Boston. In the same year he was elected to the State Senate, and two years later he became a member of the governor's council, a post of honor which had just previously been filled by another of the Original Thirteen, Dr. Luther V. Bell.

When the Boston City Hospital was opened in 1864, Dr. Stedman was appointed visiting surgeon, and at the time of his death on June 7, 1866, he was the senior surgeon at that hospital. The tradition established by

Dr. Stedman with regard to mental hospitals was carried on by his son, the late Dr. Henry R. Stedman, who for many years operated in Boston a private hospital for mental disorders.

FRANCIS T. STRIBLING was in a peculiar sense one of the progenitors of the Association. We are told in his own words that it was at a visit made to him at Staunton, Virginia, by Dr. Samuel B. Woodward that the desirability of an association of superintendents was discussed, as a result of this initial conversation the organization meeting was held in the following October.

Dr. Stribling was born on January 20, 1810, in Staunton, Virginia, the town in which he was destined to spend almost his entire life, and of which he was one of the most honored citizens. His father was the County Clerk, and young Francis worked in his father's office for several years, until he decided to study medicine. He "read" with one of the local doctors, attended a session at the University of Virginia, and after spending a year at the University of Pennsylvania received his degree from that institution in 1830. He practiced for a time in Staunton, and at the age of twenty-six was elected physician to the Western Lunatic Asylum. Upon his election he made a tour of the better-known institutions of the Northern and Middle Atlantic States, and returned to incorporate into the operation of the Asylum what was then considered the best in institutional practice and in the care of the mentally ill. He met a cordial response from the State Legislature, as well as from the Board of Directors of the hospital.

He was not a prolific writer; indeed, aside from his annual reports only one item appears in his bibliography—an article in the *American Journal of Insanity* for 1852 on the "Qualifications and Duties of Attendants on the Insane." A reading of the reports written by Dr. Stribling indicates his interest in progressive ideas and emphasizes his kindly and humane attitude toward the objects of his care. In his annual report for 1845 he comments that whereas his former reports had dwelt on insanity in general, that practice is no longer necessary, since "a most valuable periodical has been established for this purpose at the Utica Asylum in New York." This was, of course, the *American Journal of Insanity*, founded by Amariah Brigham in the previous year and designed, as Dr. Stribling says, "to interest and instruct the general reader, especially members of the medical and legal profession."

Stribling emphasized the importance of avoiding deception in inducing the patient to go to the hospital, and he urged early treatment in order to justify a reasonable prospect of cure. Kindness, he said in his report for 1846, "is the great moral agent upon which we have mainly relied." The novel doctrine of nonrestraint, he said, was not so adapted as to leave "these unfortunate individuals to the sway of their own morbid appetites or unbridled passions." That he was a devotee of the small institution is clear from a statement in his report of 1853, that the Western Asylum was "one of four which all admit to be too large." He early recommended the training of attendants, and was a strong advocate of occupational therapy.

With the advent of the Civil War the troubles of the asylum were considerably increased, but Dr. Stribling carried on manfully and in spite of greatly contracted budgets evidently did his best to give the patients adequate care. It is much to the credit of the administration of the State which succeeded the Civil War that Dr. Stribling was left undisturbed and that reasonable funds were appropriated for the continuing administration of the hospital.

Dr. Stribling took an active interest in the affairs of the Association and was a constant attendant at the meetings. He died at Staunton on July 23, 1874.

Such were the personalities which brought forth the Association. Finer tribute to their ability and their motives can hardly be paid than was expressed in the words of Dr. John Curwen in his presidential address just a half-century ago: "With high resolve and determined purpose these gentlemen aimed to impart correct knowledge and inaugurate a new system of treatment which would commend itself to the minds of all. They were the friends and promoters of progress; steady, consistent, persistent, not lured away from the true path by theoretical philanthropists and visionary schemers, but animated by a calm consideration in their adherence to justice, truth and right, and guided by a faith which enabled them to look beyond the cloud bank of temporary expediency to the ever-enduring realities."

SAMUEL W. HAMILTON

THE HISTORY OF AMERICAN
MENTAL HOSPITALS

MEDICAL history is continuous. Not all that is good in hospital practice is recent, nor is all that is bad old. If traces of poor practice survive in mental hospitals today, so do the best features of present practice have their roots in what our predecessors devised.

Hospitals for the mentally ill developed from other kinds of institutions. Under pioneer conditions every family was responsible for the care of its sick. Most families in this country seem to have tried with a right good will to take care of their mentally ill members, but to manage a delusional, delirious, or otherwise aggressive person was very difficult even in such large families as prevailed in the seventeenth century. Obviously other than ordinary means of caring for patients had to be found.

Jails were strong enough to hold disturbers of the peace, and to them were taken many of the mentally ill. In the centers of population another type of institution developed—the workhouse. Those who became physically crippled, those who were dull of mind, those who were troublesome but not unmanageable, and those who were bereft of reason, all were harbored here. The first one, built in New York in 1736, was well called the “Poorhouse, Work-house and House of Correction”;¹ in the cellar at one end of the building were some special dungeons for the mentally ill. Similar institutions had been authorized in Rhode Island and Connecticut. The mixture of dependents and idle people and those who misbehaved was sufficiently disagreeable so that every reasonable and ambitious person would try to keep himself and those in whom he was interested out of such an institution.

Another type of institution was the almshouse, where strong cells might be built for the more disturbed patients. This indeed cared for the same groups of persons as did the workhouse, except that it did not receive those who had broken the law, its mixture of population was therefore probably a little less objectionable. Almshouses existed late in the seventeenth century but were not general until the middle of the eighteenth.² For more than a century the greatest number of the mentally ill were cared for in almshouses.

¹ Minutes of the Common Council of New York City, 1675-1776, IV, 310. Quoted by Deutsch, *The Mentally Ill in America* (New York, Doubleday, Doran & Company, 1937), p. 52.

² Hurd, ed., *The Institutional Care of the Insane in the United States and Canada* (Baltimore, Johns Hopkins Press, 1916-1917), I, 89.

For many years after the settlement of this country such arrangements were the best that could be offered; they certainly compared favorably with the dens that were occasionally built on some secluded farm, or with the methods followed in Asia and Africa. Thus the earliest stated receptacles for the mentally ill were sections of charitable institutions that were not hospitals. Hospitals indeed were a great rarity and little like those of the present time in concept or in performance. The creation of special hospitals and of sections of hospitals for the mentally ill marked a great advance. Even though the hospitals broke only gradually with the traditions of their predecessor institutions, they embodied the fruits of medical knowledge and the ideals of medical practice.

The first definite hospital ward for the mentally ill of which we have a record within the area served by the American Psychiatric Association was a small building that the second Bishop of Quebec, Monseigneur de Saint Vallier, erected close to the General Hospital at Quebec in 1714.³ Women were cared for there, and later the government put up a similar house for twelve men. One who lacks medical and historical perspective may be troubled by the available descriptions of this crude place whose eighteen cells, 8 by 7½ by 8 feet in size, were designed simply to confine the patients rather than to accomplish anything important in their treatment. Sanitation was primitive. There is no occasion for adverse criticism, however, since such a standard prevailed throughout the civilized world and millions of mentally ill had less humane accommodations than these. Unfortunately, more was undertaken than the nuns in charge of the building at Quebec had means to carry out, and by 1762 the institution was in an impoverished and lamentable condition.

The first and second general hospitals in the United States, the Pennsylvania Hospital and the New York Hospital, both antedate the Revolution, although the institution in New York was not opened until 1791. From the first, both hospitals professed an interest in the mentally ill. This sweeping inclusion of mental illness with other illnesses was very creditable to the insight of the time, and may well be emulated at the present day. Each of these hospitals at first made provision for the mentally ill in the basement.

There were various reasons why Philadelphia was the site of the earliest hospital.⁴ It was the largest city in the country and correspondingly wealthy. It had a large Quaker population, and members of the Society

³ *Ibid*, IV, 245

⁴ *Ibid*, III, 381.

of Friends have ever been humane and benevolent citizens. In 1709, at a monthly meeting of the Friends Society in Philadelphia, it was proposed that a hospital be erected for members of the Society who might become sick or insane.⁵ That plan was not carried out, but in 1750 a number of citizens of various faiths urged that a hospital be established. In 1751 the provincial assembly passed an act to encourage the project and offered a grant of half of the first four thousand pounds. Accordingly, the Pennsylvania Hospital was opened in 1752; it received its first mental patients—two women—the same year, and they were cared for in a separate building. The original hospital is still in use.

The medical scope of the New York Hospital was no less broad than that of the Pennsylvania Hospital.⁶ Strong rooms were built in its basement, but within five years its service to the mentally ill was so much appreciated that a third story was added to each of the two wings in order to accommodate the increasing numbers. In 1808 the board of governors put up a separate pavilion for mental cases to one side of the main building; in 1821 those cases were moved to the new Bloomingdale Asylum in the country. The Pennsylvania Hospital made a like separation in 1841.

The first institution designed solely for the care of the mentally ill was opened at Williamsburg, Virginia, in 1773.⁷ It was set up under the title, "The Court of Directors of the Public Hospital for Persons of Insane and Disordered Mind." The appropriations were £12,000 for buildings and a maintenance rate of £25 per annum for each patient—a liberal allowance in view of the small amount of medical and technical care that was required under the standards of those days. In February, 1841, by act of the Virginia Legislature, the office of Medical Superintendent of the Eastern Lunatic Asylum at Williamsburg was created. Dr. John Minson Galt was the first to be appointed to this office. In the course of decades the institution developed into a creditable mental hospital; before that it had been at least a creditable refuge.

The same humanitarian trend shown in the establishment of the institution at Williamsburg existed in all the colonies as well as in the states and provinces after the political structure of the United States and Canada was differentiated. In the northern seaboard states more reliance was placed on private initiative. The Maryland Hospital opened in 1798.⁸

⁵ *Ibid.*, I, 88.

⁶ *Ibid.*, III, 133-141

⁷ *Ibid.*, III, 703-711

⁸ *Ibid.*, II, 512

In Philadelphia the capacity of the Pennsylvania Hospital was limited, and accordingly the Friends Hospital was founded and opened its doors in 1817.⁹ Massachusetts followed with McLean Hospital, and Connecticut with the Hartford Retreat (now the Institute of Living), founded through the efforts of the state medical society.¹⁰ Beyond the Alleghenies the Eastern State Hospital of Kentucky was opened in 1824. South Carolina opened a public institution in 1828, and Virginia's second mental hospital at Staunton opened the same year.¹¹ The first public asylum in Massachusetts was opened in 1833 at Worcester.¹² The first separate institution for the mentally ill in Canada was a small wooden building in the City of St. John, New Brunswick, originally erected as a cholera hospital and converted into an asylum in 1835.¹³ It remained open only a few years.

In 1836 one more corporate institution was added to the list, at Brattleboro, Vermont.¹⁴ Then came institutions at Columbus, Ohio, in 1838, Boston, Massachusetts, and New York City in 1839, at Augusta, Maine, and Nashville, Tennessee, in 1840.¹⁵ Two more were opened in 1842, at Milledgeville, Georgia, and Concord, New Hampshire.¹⁶ In 1840 the Sisters of Charity, who had by contract taken care of the mentally ill for the City of Baltimore in the Maryland Hospital, dropped that arrangement and established what later became Mt. Hope Retreat.¹⁷ New York State opened its first mental institution at Utica in 1843.¹⁸ In addition to these there were also two private institutions in New York and one in Massachusetts. This completes the list of institutions separately established and separately maintained for the mentally ill, either as public or private enterprises, up to the time of the organization of the Association whose centenary is being celebrated.

To recapitulate: In 1844, a hundred years ago, there were twenty-two public and corporate institutions for the mentally ill and three private institutions in the United States, one in New Brunswick, one in Ontario, and psychiatric services were attached to two general hospitals in Quebec. Of the public institutions in this country, Georgia, Kentucky, Maine,

⁹ *Ibid.*, III, 383, 384.

¹⁰ *Ibid.*, II, 599-601; II, 76-81.

¹¹ *Ibid.*, III, 587-592, III, 704.

¹² *Ibid.*, II, 63-78.

¹³ T. J. W. Burgess, *Am J Insanity*, LXI (1904), 3.

¹⁴ Hurd, *op. cit.*, III, 675-678.

¹⁵ *Ibid.*, III, 303; II, 645; III, 115, II, 488; III, 636.

¹⁶ *Proceedings of the Am Medico-Psychological Assn*, IV (1897), 108, Hurd, *op. cit.*, III, 33.

¹⁷ Hurd, *op. cit.*, II, 550.

¹⁸ *Ibid.*, III, 152, 153.

Maryland, Massachusetts, New Hampshire, New York, Ohio, South Carolina, and Tennessee had one state institution each, and Virginia had two. Institutions on foundations existed in Connecticut, Massachusetts, New York, Pennsylvania (two), and Vermont. One institution was maintained by the County of New York, one by the County of Kings (New York), one by the City of Boston; one was a church hospital in Baltimore. The private institutions were in New York City, Hudson, New York, and Pepperell, Massachusetts.

The original building at Williamsburg was a very simple structure; it burned in 1885 and unfortunately the correct picture of it is lost.¹⁹ The separate building of the New York Hospital was a two-story and two-basement I-shaped structure with ten single rooms in the stem and larger rooms at the ends. The Friends' Asylum and the Hartford Retreat reproduced the scheme of the York Retreat in England, which was a three-story, attic and basement structure with two-story-and-basement wings. We are told that the institutions at Brattleboro, Vermont, Concord, New Hampshire, Worcester, Massachusetts, and Augusta, Maine, were all influenced structurally by the Hartford Retreat. In these buildings efforts were made to accommodate the most patients at the least possible cost.

English architecture was followed in the plan of McLean Hospital and later of Butler Hospital (Providence, 1847).²⁰ These were corporate institutions—on foundations—and though their boards were disposed to be economical they did not have to pare every penny. The State Hospital at Columbia, South Carolina, was a fairly close copy of McLean Hospital, which had grown out of a private mansion designed by Bulfinch. One of the most beautiful structures of that period is the original building at Staunton, Virginia, opened in 1828. Dr. Hurd remarks its many suggestions of French influence.²¹

Utica is the site of the first institution erected by New York State. The original building has a noble Doric front, four stories in the center and three in the wings. The Provincial Lunatic Asylum of Toronto, opened about the same time, enclosed a quadrangle.²² While in good taste for a building of such purpose, it is more ornamental than the one in Utica and has a dome of considerable height.

In 1841, two years before the Utica institution was opened, the Penn-

¹⁹ G. W. Brown, personal communication, 1943.

²⁰ Hurd, *op cit*, II, 601, III, 556

²¹ *Ibid.*, I, 205

²² *Ibid.*, IV, 130.

sylvania Hospital moved its patients out into the country to a new building in West Philadelphia.²³ The plan of the structure was devised by an English architect living in Philadelphia. Over a half-story basement was erected a three-story center with a dome, and two-story wings. This plan had various defects, and they were fruitfully studied by the first superintendent, Dr. Thomas S. Kirkbride, whose influence on the architecture of mental hospitals was enormous.

None of these institutions was established with ease, and in most places strenuous public support was required to win the adoption of each new project. Natural conservatism accounted for a great deal of the opposition. Unwillingness to divert money from the pocket of the taxpayer to the support of a rather contemned group was usually the hardest difficulty to overcome. Public-spirited men and women, often but not always led by the medical profession, had to agitate persistently until the need was met.

By the year 1845 two figures had emerged who were to be held in grateful honor in the history of the care of the mentally ill. They both played large roles in the story of the Trenton State Hospital. Dr. Kirkbride has been mentioned. At Trenton he crossed the trail of a woman who had an extraordinarily fruitful career in aiding the cause of the mentally ill.

Dorothea Lynde Dix was at one time a schoolteacher in Massachusetts,²⁴ but her health was poor and she retired. She accepted an invitation to conduct a Sunday School class in a neighboring jail, and there for the first time she became acquainted with the squalor and heartless indifference surrounding the insane. She promptly attacked the problem at a practical level. There was no heat in the cells for the insane, and the jailor said the insane needed no heat; Miss Dix went to court and got an order for heat. She spent the next two years visiting the almshouses and jails of Massachusetts and presented her unpleasant findings to the legislature in terms that could not be evaded, although her recommendations for remedies were stoutly opposed. Presently money was found to make a generous enlargement of the state mental hospital at Worcester. Miss Dix then crossed the line into Rhode Island and made use of vigorous and effective publicity. She won a large subscription for a new hospi-

²³ *Ibid.*, III, 402-405

²⁴ Helen E. Marshall, *Dorothea Dix* (Chapel Hill, N. C., Univ. of North Carolina Press, 1937), see also chapter I this volume, "The Beginnings, from Colonial Days to the Foundation of the American Psychiatric Association."

tal from a rich man who was known to be penurious and who originally had felt no interest in the cause that she presented.

In New Jersey she engaged in a strenuous struggle which ended triumphantly in the establishment in 1845 of the first state hospital at Trenton. She was especially proud of this institution, when she became an old lady, worn with the passage of time and her unremitting devotion to the cause of better treatment for the mentally ill, she was given a room in the administration building in which to spend her last few years. She had carried her campaign to every state east of the Rocky Mountains, and at the end of it there were thirty institutions that owed either their establishment or some notable enlargement to her efforts. Abroad, as at home, Miss Dix was held in such high respect that her observations on what she saw were listened to and her pleas resulted in betterment of British institutions. The same respectful attention was given her in the city of Rome, and a new institution was promised there.

Of course these were not one-man campaigns. The most generous-minded citizens of any commonwealth in which Miss Dix labored could be counted on to labor with her, but often the band was very small when it started. Movements that had been initiated by others but were not going successfully were vivified by her entrance. She was called hither and yon to contribute her technique of strategy and her flashing vigor of expression to the documents that marked the progress of each effort. When she passed away at the ripe age of eighty-five, she was characterized by Dr. Charles H. Nichols as "the most useful and distinguished woman America has yet produced."

While Dorothea Dix's major efforts were devoted to the establishment or enlargement of mental institutions, Dr. Kirkbride's chief interest was rational planning of hospital buildings. He developed a definite and practical set of floor plans for mental hospitals. They were first adopted at Trenton in 1845, and they achieved wide usefulness and popularity. The Kirkbride type of building consisted essentially of a series of blocks with a characteristic arrangement.²⁸ The center block held offices, quarters for staff and employees, and an amusement hall. Other blocks housed patients. The blocks were attached to each other either directly or by an offset passage, but each was set back from its more central neighbor far enough to let light and air travel from end to end of the central corridor

²⁸ Thomas S. Kirkbride, *On the Construction, Organization and General Arrangements of Hospitals for the Insane* (2nd ed., Philadelphia, J. B. Lippincott, 1880), pp. 54-57, 90-96.

of every section. When an institution outgrew its plant, the number of blocks could be increased, thus lengthening the frontage. A picture of one such hospital shows no less than ten blocks arranged in traditional fashion, each pair set back a little from the line of the pair in front. If the distance from tip to tip of the wings threatened to become too great, the plan was modified and some blocks were pointed toward the rear, making a U-shaped structure. When the Buffalo institution was opened in 1880, the distance for a physician to walk in making rounds to either end was a half mile. Since there were few physicians in these institutions, such a wide distribution of patients made medical oversight difficult. Delivery of steam through the basement was not satisfactory, and exposed sections were hard to heat. The early buildings were equipped for indirect heating—it was some time before administrators thought it safe to have radiators in the wards, particularly in those for the disturbed and indifferent groups who were likely to be housed at the far end of the wings. Ultimately these difficulties were solved by an increase in the number of physicians and radiators, and the better Kirkbride buildings with their generous corridors, comfortable sitting rooms, numerous bedrooms, and plentiful window space are still used with great satisfaction. But too many were poorly built and needed many repairs.

The mental institutions were planned first of all to give proper housing to the most disturbed people in the community. Later another type of patient needed consideration. Patients of this type were restless and active but well controlled. Rather than close confinement, they needed space in which to move and work. To care for their needs, a special wing was sometimes thrown out from the main structure, embodying fewer rooms and larger dormitories. Sometimes special buildings were erected away from the main one. There might be a so-called “lodge” for a few disturbed patients.²⁸ Most outlying structures were called cottages, probably because the first ones were farm houses converted to the use of patients. Some structures housed one, two, or even three hundred patients, but they were still called cottages. As a rule a hospital “cottage” has very few small rooms and beds its patients mostly in dormitories.

Still the pressure for accommodations continued. After considerable discussion—most of it unfavorable—the State of Illinois embarked on the building of an institution at Kankakee that was to be very largely on the cottage plan. The principal credit for this move belongs to the then secre-

²⁸ *Am J Insanity*, XXXIII (1876), 33, 138–189



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tary of the Illinois Board of State Charges, Frederick H. Wines, who had the very able collaboration of Dr. Charles E. Dewey, the first superintendent at Kankakee.²⁷ So many were skeptical of trying to care for the mentally ill in any structure that differed widely from the Kirkbride plan that the hospital centered on a central building with wings. Radiating from it were four rows of detached buildings, thus distributed with the idea that their appearance would simulate a village. The village idea was carried out more extensively at Craig Colony for Epileptics in New York State, where buildings were scattered around the hillsides in several groups.²⁸ Numerous institutions for mental defectives and a considerable number of mental hospitals now exemplify the cottage plan.

When a cottage is at the distance of two or three miles from the main institution, and particularly if it is surrounded by farm land, it is likely to be called a colony. The first of many such offshoots was established by Kalamazoo State Hospital in 1885.²⁹ Some colony buildings were cheaply built houses, with consequent heavy costs for upkeep; others have been of substantial construction. Administration is a little more difficult because of distances, but patients are chosen from those able to look after themselves in most details. In 1914 it was stated that three miles from the parent institution was as far as a colony could practicably be placed; this was probably true in the days of horsedrawn vehicles, but distance is of little consequence when motor transport is available.

While the colony plan makes easier the work of running the farm, it has also a psychological effect quite as great as the industrial value. Patients like to be away from the jumble and noise of the main institution; they like the feeling of privacy that comes with relative isolation. They are able to get their food a bit quicker and therefore hotter from their own kitchen, and if the number in the colony is not too great, the variety and skill of the cookery are apt to excel that of the main group.

A style of building that has not been widely used in this country may be called the connecting passage type. This is essentially a series of blocks brought into association by corridors of some length. The new plant of the Bloomingdale Hospital, opened in 1894, is of that style, with passageways two and in some instances three stories high. A part of the plant of the Philadelphia State Hospital, erected somewhat extravagantly by the

²⁷ *Recollections of Richard Dewey* (Chicago, Univ. of Chicago Press, 1936), pp. 129-141.

²⁸ Hurd, *op. cit.*, III, 253.

²⁹ *Ibid.*, II, 773.

City of Philadelphia, has very liberally glazed passageways connecting eight pavilions, the administration building, and dining rooms. At Newberry, Michigan, there is a very attractive example of what can be done with a one-story corridor.⁸⁰ Buildings surround a ten-acre quadrangle and their inner façades are connected by an arched ten-foot cloister, affording a continuous, sheltered, open-air promenade around the large central court with its lawns, flowers, shrubs, and trees. In winter these arches serve as frames for windows, for the climate is severe. A carefully planned corridor hospital is the one at Foxborough, Massachusetts, where Dr. Albert C. Thomas, a meticulous builder, was superintendent. He started with three existing buildings and added five, forming an L-shaped group. The passageway is of two-story-and-basement height, and so broad that several segments are used as sitting rooms for the adjacent wards. Necessary traffic can flow through these sitting rooms; service traffic circulates at the basement level. The Veterans Administration Facility at Northport has used the connecting corridor very skillfully, enclosing a "great court" and a smaller one.

In the six years following 1844, six new institutions appeared. Butler Hospital was established by a foundation,⁸¹ the states of Indiana, New Jersey, and Louisiana opened institutions;⁸² and a county in Iowa and another in Wisconsin started asylums.⁸³ The institutions of the decade before the Civil War were scattered from Taunton in the East to Stockton in the West.⁸⁴ The District of Columbia was for the first time represented.⁸⁵

In the border states, Kentucky erected its second mental hospital and Missouri its first.⁸⁶ The institution farthest north was at Mendota, and the two in the south were in North Carolina and Mississippi.⁸⁷ The stricken Southern states did little during the sixties, but with the aid of the Federal Army Virginia started a Negro institution (now at Petersburg) that has had in some regards an outstanding history.⁸⁸ Alabama

⁸⁰ *Ibid*, II, 813.

⁸¹ *Ibid*, III, 554-557.

⁸² *Ibid.*, II, 322-324, III, 58-65, T. O. Powell, "A Sketch of Psychiatry in the Southern States," *Transactions of the Am. Medico-Psychological Assn.*, XIV, 118.

⁸³ *J. Am. Med. Assn.*, XC (1928), 937, 978.

⁸⁴ Hurd, *op. cit.*, II, 30.

⁸⁵ *Ibid*, II, 144, 145.

⁸⁶ *Ibid*, II, 459-461, II, 878-879.

⁸⁷ *Ibid*, III, 840-841, III, 282, II, 871.

⁸⁸ *Ibid*, III, 733-736.

opened a state hospital in the year before the war broke out,³⁹ Texas in 1861.⁴⁰ Other state institutions, distributed from Rhode Island to Oregon, began their work, and Wayne County, Michigan, started an institution at Eloise.

In the eighth decade of the century a complete plant of an important school for defectives was erected in Illinois, and Worcester, Massachusetts, was given an entirely new plant on the outskirts of the city.⁴¹

Numbers increased extensively in later decades, particularly when one adds the numerous county institutions to the toll. In Iowa the date of opening of many is unknown, so that any figures decade by decade are liable to serious error.

The Federal Government did not concern itself with the mentally ill until after the time the American Psychiatric Association was formed. There were few cases at the Capital, for the District of Columbia was small.⁴² When St. Elizabeths Hospital was opened in Washington in 1855, it made provision for cases from the District and also from the permanent services of the government. The next Federal venture into the field of institutional psychiatry was the Asylum for Insane Indians at Canton, South Dakota, that functioned from 1903 to 1934.⁴³ The picture changed when the government assumed responsibility for the mentally ill along with other casualties of the first World War. Since St. Elizabeths Hospital was the only government institution that could care for these patients, it was necessary to make contract arrangements in several places. The only considerable contract still in force is that with the State of Illinois, which takes care of Illinois patients on a per diem basis.⁴⁴ Several institutions were converted into mental hospitals. One had been an orphanage, another was a naval tuberculosis hospital, a third was an old soldiers' home. As time has advanced the old institutions have been replaced or so largely reconstructed that they appear new. The Veterans Facilities, as they are called, are widely scattered. Those that are designated for the care of the mentally ill number twenty-nine. It has been calculated that the peak load will be reached only after 1950.

In 1935 the United States Public Health Service was called on to give

³⁹ *Ibid.*, III, 373.

⁴⁰ *Ibid.*, III, 650; II, 298.

⁴¹ *Ibid.*, II, 641.

⁴² *Ibid.*, II, 141.

⁴³ *Ibid.*, III, 630-632

⁴⁴ Department of Public Welfare, Illinois, personal communication, 1941

institutional treatment to drug addicts. A hospital was opened at Lexington, Kentucky, in 1935 and another at Fort Worth, Texas, in 1938.⁴⁵ During the present war the number of addicts under treatment has decreased materially, and several hundred psychotic patients have been accommodated at Fort Worth.

All the general hospitals of the Army and Navy have cared for some mental patients during the present war. In addition, the Army set aside the Darnall General Hospital at Danville, Kentucky, for such cases. These military arrangements are expected to be temporary, since in time the patients will be transferred to the Veterans Administration or perhaps in some instances to the state of residence.

Throughout the history of the United States and Canada the capacity of the mental institutions has never long been equal to the demand of the public for accommodation. Apparently no one has been able to estimate this demand, and there have been repeated disappointments because new institutions or additions to old ones were scarcely built before all the beds were taken, and the community seemed not much better off than before. After a hundred years of observation and accumulation of statistics and analysis of trends, we can now see why our grandfathers were overwhelmed by the demand for the accommodations offered to their deviatory fellow citizens. It is possible to plot a curve for any state or province and tell how many beds ought to be available today, and how many more will be needed ten or twenty years hence in accord with past experience, but a new element has entered into these calculations and in many states our accommodations are almost as much in arrears as were those of our forebears.

The new element is the increase in expectancy of human life.⁴⁶ In the last sixty years this has nearly doubled. Accordingly the number of elderly and middle-aged people in the community has greatly increased. Since elderly people seem particularly liable to develop mental illness, the average age of mental hospital populations has increased much faster than the average age of the general population. Since no one knows where the average age of the general population will reach its peak, no one can predict what maximum of hospital beds should be sought. In many states this is purely an academic question, since the hospital accommodation is at present far below a decent minimum. Even the more liberal states cannot esti-

⁴⁵ U. S. Treasury Department, Washington, Program of Dedication Ceremonies, 1938.

⁴⁶ Dayton, *New Facts on Mental Disorders* (Baltimore, Charles C. Thomas, 1940), p. 64.

mate the ultimate need of hospital provision and continue always to be slightly behind it.

This situation is shown statistically in the following table:

TABLE I
HOSPITAL POPULATION COMPARED WITH ESTIMATED NEEDS
IN DECADE YEARS

Census year	Population (Continental United States) ^a	Per cent 15 years and over	Population 15 years and over ^d	Patients enumerated in hospitals and asylums ^e	Estimated number of persons needing hospitalization for mental disease ^h	Per cent of estimated needs actually provided
1844	19,518,422 ^b	57 0	11,116,948 ^b	2,561	83,377	3 1
1850	23,191,876	58 4	13,544,056	4,730	101,580	4 7
1860	31,443,321	59 5	18,708,776	8,500	140,316	6 1
1870	39,818,449 ^c	60 8	24,209,617	17,735	181,572	9 8
1880	50,155,783	61 9	31,046,430	40,942	232,848	17 6
1890	62,947,714	64 5	40,601,276	74,028	304,510	24 3
1900	75,994,575	65 6	49,852,441	^f	373,893	. 1
1904	81,792,387 ^b	66 3	54,228,353 ^b	150,151	406,713	36 9
1910	91,972,266	67 9	62,449,169	187,791	468,369	40 1
1920	105,710,620	68 2	68,589,464	^f	514,421	1
1923	110,705,086 ^b	68 9	76,275,804 ^b	267,617	572,069	46 8
1930	122,775,046	70 6	86,679,182	280,251 ^g	650,094	43 1
1940	131,669,275	75 0	98,751,956	461,358	740,640	62 3
1941	132,637,933 ^b	75 0	99,478,450 ^b	473,058	746,088	63 0

^a Bureau of the Census, U. S. Department of Commerce, Press Release, December 4, 1940. For 1941, Bureau of the Census, Press Release, March 22, 1943.

^b Estimated population.

^c Revised population.

^d For 1844, estimated. 1850-1920: Bureau of the Census, Fourteenth Census, 1920, *Population*, II, 154. 1930 and 1940: Bureau of the Census, Sixteenth Census, 1940, Press Release, April 10, 1942. For 1941, 1940 age distribution is used.

^e 1844-1870: E. T. Wilkins, M.D., *Insanity and Insane Asylums*, 1872, p. 191. 1880-1923: Bureau of the Census, *Patients in Hospitals for Mental Disease*, 1923, p. 11. 1930-1941: Bureau of the Census, *Patients in Mental Institutions*, 1940, p. 6.

^f Patients in mental institutions not enumerated.

^g This figure includes the insane in state hospitals only.

^h Based on a hospitalization rate of 750 patients per 100,000 persons aged 15 years and over, approximately the rate for Massachusetts in 1940, see Bureau of the Census, *Patients in Mental Institutions*, 1940, p. 8.

ⁱ Not computed.

A new project of obvious value to the community evokes enthusiasm, and hopes may run higher than experience will justify. This was the case with the treatment of the insane. Diagnosis in the earlier decades was perhaps not always sharp, and criteria were not immediately developed by

which to predict whether an excitement would end favorably or unfavorably, or whether a depression would reach recovery or would merge into a condition that was known as dementia. Indeed "insanity" was often spoken of as a disease—not several diseases, but one.

Anyone who did something for these neglected mental patients was sure to have some highly rewarding experiences. It was early noted that the happiest results were obtained with patients who did not stay very long in the hospital; a speedy recovery was likely to be a recovery that was satisfying to everyone concerned. At the same time it was noticed that speedy recovery was most likely to occur among those who had not long been sick before entering the hospital. The sharper the attack of excitement, the more definite and gloomy the depression, the shorter the course of the illness. From this was drawn the inference that a speedy recovery was more likely in the case of the patient who was brought early to the hospital. A fallacy lay here in that some patients never recover, no matter how late or how early they are taken to a hospital. If, however, the doctor believed that insanity is all one disease, and if he saw a series of relatively fresh cases getting well and a series of longer cases staying on at the hospital and continuing to be invalids, he might easily come to the partially false conclusion that early admittance meant early recovery. Some of the most ardent propagandists, both medical and lay, felt sure that a series of institutions, perhaps one in every state, which maintained the confidence of the medical profession and of the community would produce cures in so many cases of mental illness that the chronic case would be a rarity. Earnest arguments were put forth in annual reports and in discussions at medical meetings, to the effect that the mentally ill should be diagnosed earlier and brought sooner into the asylum.

Time went on. Many patients got well; others got well enough to leave the hospital; but persistently chronic cases accumulated. When a hospital was filled up with patients who never got well no matter what efforts were made in their behalf, the work grew less interesting; much worse, the community failed to get help when a new case developed, for there would not be room for him in the hospital. The mental hospitals represented a considerable investment, and it seemed wrong to devote them increasingly to the care of chronic cases. Because of the desire to make the best use of a good investment, as well as the cry for beds to receive excited cases of mental disease freshly developed, patients with established illness were moved out of the mental hospitals. (Even in the 1940s some institutions

have been able to take a new patient only by insisting that the county of origin take back one of their older cases.⁴⁷) If a patient had not improved enough to live with his own family, it was thought that perhaps he could get along in the almshouse, particularly if the almshouse requirements for the peace and comfort of other inmates were not too high. Occasionally a patient went directly from the hospital to jail. Not infrequently a discharged patient became worse and presently took his place on the waiting list of the same institution from which he had been removed.

Even before the Civil War it was evident that a chain of pleasant public hospitals, one or two to a state, was not sufficient. Some psychiatrists insisted that enough hospitals of standard size (at first thought to be not over two hundred and fifty beds) could be built to accommodate all patients; others believed that the states could not catch up in this way. County institutions were increasing in size, particularly in the larger states. Almshouses, as is well known, are usually run with extreme economy, generally they were overcrowded. Then as now a patient relatively comfortable in mind could also be comfortable in body in such an institution. The disturbed were carefully restrained and well secluded in the almshouse, but got little attention. Treatment was given by a physician who came once or twice a week, or oftener if called, but who was apt to be on contract for total service rather than for the number of visits made. Medical observers seldom thought that the treatment afforded was satisfactory.

Since New York had the largest population, its problem was big statistically. The pitiful condition of patients in the county institutions had been one of the strongest grounds for urging state authorities to erect the Utica Asylum and the others that followed, but the poorhouses still held hundreds of insane. The superintendents of the poor convened and asked to be relieved of the insane.⁴⁸ The resulting dilemma gave rise to heated argument at more than one session of the Association of Medical Superintendents, and such debates were merely sideshows to discussion in the press, at meetings of other medical societies, and in public gatherings. Some insisted that no compromise should be made with the principle that institutions should be small enough so that the superintendent could know all his patients intimately. But their position was somewhat weak-

⁴⁷ Personal communications, West Virginia, 1942.

⁴⁸ *Report and Memorial of the County Superintendents of the Poor of this State on Lunacy and Its Relation to Pauperism and for Relief of Insane Poor*, 1856 (New York Senate document, 1856), Vol I, doc 17

ened by the fact that this original proposition had been modified after New York built accommodations for six hundred at Utica instead of two hundred and fifty, which number was generally thought to be plenty for a superintendent to care for. And no one could get around the fact that the existing institutions and the two new ones going up at Buffalo and Poughkeepsie would not be able to care for all the mentally ill of the state. The Association, however, did stand fast in recommending six hundred beds as the limit of size of a mental institution.

The counsel of the Association was finally disregarded; a new kind of institution (for this country) was built in New York in 1869. It was named the Willard Asylum, after a distinguished officer of the State Medical Society, whose benevolent eloquence was stilled by death just as the construction of the hospital got under way.⁴⁹ This hospital was to take fifteen hundred patients if necessary. It was planned that it would empty the county asylums as well as receive patients who did not benefit sufficiently by a few months at Utica to enable their friends to take them home. This then was the first medical institution—as contrasted with county institutions presided over by laymen—established definitely for the purpose of giving humane care to all the long-continued cases. It was expected also that this care would be economical. In later years similar institutions were established at Agnew, California; Peoria, Illinois; Gardner, Grafton, Medfield, and Tewksbury, Massachusetts; Anoka, Hastings, and Willmar, Minnesota; Binghamton, New York; Wernersville, Pennsylvania; Howard, Rhode Island; Sedro Woolley, Washington; Huntington, West Virginia; and Mimico, Penetanguishene, and Cobourg, Ontario.

This arrangement ultimately turned out to be unsatisfactory. People objected to having their relatives classed as incurable, and many patients themselves were very resistant to that label. The hospital for chronic cases was likely to look just as attractive as the hospital for acute cases, families who lived near by wished to have it equipped for their acutely sick relatives, for convenience in visiting them. But there was constant dissatisfaction with professedly chronic institutions, and from time to time they were given reception facilities and districts of their own. This happened at Willard in 1890, twenty-one years after its opening.⁵⁰ As the Association century comes to an end no chronic hospital remains except that at Cobourg.

⁴⁹ Hurd, *op cit*, III, 160-162

⁵⁰ Personal letter from H. M. Pollock, New York Department of Mental Hygiene, 1943.

Most states abandoned county care rather early, but when the pressure for hospital beds became severe in the latter part of the nineteenth century some reverted to it. Wisconsin in particular set up a large county system, and of late years—making a virtue of necessity—has asserted boldly that its system gives the best management of the mentally ill.⁶¹ All fresh cases in that state are expected to be received in one of two state hospitals. If within a year they still need treatment and are not well enough to go home, they are transferred to a county asylum. The state hospital accordingly is the place for all new cases, as well as for old cases that continue disturbed. Unhappily the state has not seen its way to carrying out its end of the program by providing beds enough for new and disturbed patients, and has found it necessary to transfer many patients to the county hospitals long before a year was up.

The Iowa system is very like that of Wisconsin, but Iowa has four state hospitals. New Jersey allows option to its counties, and one of the best hospitals in the state is maintained by a county, the other five county institutions are less esteemed.⁶² Pennsylvania granted the same option to counties or to sections of counties known as poor districts, and several county institutions were well thought of. In one, however, the situation became so vile that there was a legislative investigation, following which the state took over all county institutions, closed some, and improved others and added them to the state hospital system. Michigan has one county institution, and Tennessee four. Missouri permits all its counties to retain their mentally ill but makes it unprofitable to do so by paying a considerably larger part of the patient's care if he is in a state instead of a county institution.

The benevolent foundations that undertook the care of the mentally ill were managed by boards, called directors, trustees, or governors—according to the usual corporate style. Many of the ablest community members have acted on such boards, giving to them a service and prestige that could not have been purchased. Institutions maintained by religious orders had no special board but relied on the advice and moral support of their ecclesiastical organizations.

Each state at the inception of its effort to care for the mentally ill established a board to govern its new institution. In Virginia these boards were called the court of directors, in Maryland and the District of Columbia visitors, in New York managers, and in many states trustees. Not infre-

⁶¹ Hurd, *op. cit.*, III, 826–837.

⁶² *Ibid.*, III, 54

quently there were two boards, one to build the institution and another to run it. Noted citizens contributed their services, some for decades at a time. They handled the business of the institution at board meetings, they inspected the property; not infrequently they kept up acquaintance with a considerable number of patients, they answered inquiries in the community about those who were under care. They maintained the interests of the institution with the governor and saw to it that the legislature gave it proper support. •

Board members were usually reimbursed for their traveling expenses but received no salary. The community was in no position to pay salaries at all commensurate with the standing of such men in the business world. It was thought that if small salaries were attached to the positions, men of high type would be offended rather than gratified, whereas picayune persons who were out of a job might be attracted by a few dollars and make service on the board obnoxious to abler persons.

The neighborhood usually felt proprietary interest in the hospital, wanting its trade and its jobs. Fortunately, in most states there has been no descent from the high ideals existing at the time of the founding of the hospitals, but in too many others the treatment of patients has been subordinated to the support of whatever political group happened to be in control of the state government at the time. In some states paid boards were substituted for voluntary boards to make the available jobs politically attractive.⁵³ In order to spread the gravy farther, the size of the boards was then cut down and the five, seven, or nine trustees were reduced to perhaps three, with larger salaries. Administration by such paid boards was much poorer than that afforded by their unpaid predecessors.

In a few states employees have been called on repeatedly to contribute to party funds. In some, the superintendent is dismissed when the governor changes. A hospital in Illinois had eight superintendents in sixteen years, and one in another state had thirteen superintendents in nine.⁵⁴ Under such arrangements it was of course impossible to maintain good standards, for the occasionally progressive superintendent appointed under this system could do no more to make his progressive measures permanent than could the usual mediocre "political doctor." In certain states it has now become more fashionable to retain the medical staff but to replace most other employees. Happily some states in which political

⁵³ *Ibid*, I, 180.

⁵⁴ *Transactions of the Am Medico-Psychological Assn*, XXIII (1916), 415

domination once prevailed became disgusted and discarded it. On the other hand, some state occasionally lapses from better standards and replaces persons of experience with tyros who happen to have voted right.

Changes in administrative organization came naturally with the gradual increase in the number of institutions, particularly in the second half of the nineteenth century. When a state had an institution for the blind, another for the deaf, a prison or reformatory or two, a state hospital (or perhaps two), there were inevitable clashes of interest in fiscal matters. Governors and appropriations committees are quite willing to hear the pleas of a considerable number of separate groups, but the time comes when patience is exhausted and they want to deal with one body rather than several.

Boards of charities and corrections became a popular feature of the political organization of many states.⁸⁵ These boards were often composed of prominent persons. They generally exercised a considerable visitorial responsibility and sometimes maintained a secretary who had reputation and influence, but the influence was usually unaccompanied by any direct administrative authority. Members of the board visited all sorts of public institutions and presented their findings to the governor and the legislature. In some states they were listened to with great respect. A tendency developed, however, for governors to appoint board members who were well intentioned but uninfluential, and the time came when the work of many boards was more statistical and historical than practical. Unhappily the "practical" people with much lower ideals than those of the boards of charities and corrections were likely to get posts on the institution boards, where they could determine how they should be run and particularly from which groups their personnel should be recruited.

Just before the turn of the century a further movement toward centralization of administrative authority spread through the Middle States, and boards of control were set up to govern all sorts of public institutions. Board members were salaried and gave most of their time to this work. The salaries were seldom large enough to assure uncommon ability, but this is typical of American political life, where the public always hopes that it can hire \$30,000 worth of brains for \$3,000.

A different development took place in a few of the larger states—Massachusetts, New York, Pennsylvania. The boards of charities ceased to carry responsibility for the inspection of the mental hospitals in these

⁸⁵ Hurd, *op cit*, I, 181.

states, this duty was assigned to a Board of Insanity in Massachusetts, to a Commissioner in Lunacy in New York.⁶⁶ Out of such bodies grew such powerful boards as exist today in those states and in Missouri, and bureaus as in Pennsylvania and Wisconsin. In the present century many boards have been replaced by single commissioners or directors.⁶⁷ Large state departments dealing with mental problems alone were naturally headed by experienced psychiatrists. However, the law requiring that arrangement was repealed in New York in 1943, leaving the governor free to appoint whomever he might wish without regard to qualifications.

Central control is no unmixed blessing. In more than one state it has made political manipulation of the institution payrolls easier to accomplish. It must be remembered, however, that such political manipulation does not depend upon the type of government in a state but upon the standard of public opinion. The progress of centralization was not smooth; it was accomplished only against sharp opposition, some of it from prominent members of the Association.⁶⁸ Such schemes roused the bitterest resentment, as is shown in the minutes of the Association. Some superintendents said that they would resign if anything of the sort were put into effect in their states, and probably they would have done so. Indeed, some strong administrators in later years have moved across a state line, from the growing central control in one commonwealth to a freer atmosphere in another.

Self-sacrifice and genius in meeting difficult situations are commonplaces of the practice of medicine that were particularly called for in some Southern hospitals during and right after the Civil War. Only heroism and unremitting doggedness enabled some of the administrators to keep even a handful of patients in the hospitals. Money was scarce and state governments did not always spend it wisely. In South Carolina members of the board borrowed on their individual credit to tide over a crisis.⁶⁹ When Columbia was burned by Sherman's army, hundreds of citizens crowded into the state institution seeking shelter and safety. In 1870 the superintendent reported that he had been unable to cash warrants for more than a year and had borrowed \$10,000 from some benevolent Friends in Philadelphia.

Much has been said, pro and contra, about the professional spirit of

⁶⁶ *Ibid.*, II, 593, III, 118.

⁶⁷ E.g., Massachusetts, New York, Pennsylvania

⁶⁸ See *Am J Insanity*, XXI (1864), 152-155, also, XXXII (1876), 345-354

⁶⁹ Hurd, *op cit*, III, 597-601.

the physicians who have staffed the mental hospitals. Some of the discussion has suffered from too wide generalization. Among those who first undertook institutional psychiatry the level of ability and energy was notably high. Mediocrity always follows after genius, and no doubt a considerable number of less competent men were gradually annexed to staffs in states that gave physicians no tenure. But the tendency elsewhere was not downward, as is evident from the careers of the men who became assistants on the staffs of the best hospitals.

The superintendents of the early institutions were pioneers in their work. Into such a movement men come with zeal not only for the work in hand but also for spreading such work elsewhere. This is sometimes called the missionary spirit, and it can be seen breathing through the pages of many a report throughout the almost two hundred years since the Pennsylvania Hospital began to care for the mentally ill. It was important to the superintendents to formulate and publish their observations and experiences for the profession. This was done in declarations of principle that were timely and most helpful to new men coming into the field, perhaps with little training. It was a function of annual reports to spread propaganda in behalf of proper treatment. In the light of present-day experience some of the claims seem exaggerated; certainly some of the grand hopes were disappointed rather promptly. But if one reads these reports, or even their abstracts that appear in the pages of the *American Journal of Insanity*, one cannot but become deeply impressed with the vigor of purpose and the cogent expression that characterized the leaders of the Association of Medical Superintendents.

The beliefs of the Association were set forth under the title of "propositions" between 1844 and 1875.⁶⁰ These propositions were principles of organization, of management, and of construction that had undergone discussion in meetings of the Association and were formulated after full deliberation. The first was adopted in 1844, and the last in 1875. While fighting the foes of indifference, ignorance, and hard-heartedness, the members made a strong point of agreeing among themselves on what they would recommend; after a discussion some members apparently voted not entirely in accordance with their private opinion, but made some compromises so that the Association would present a strong position before governors, legislators, and other public authorities. This is what law-making bodies also do. There seems to have been no hesitation in

⁶⁰ *Ibid.*, I, 217-222.

speaking out strongly in meeting. A debate that perhaps roused the greatest eloquence was on the questions that centered around the Willard State Hospital: whether the Association should resolutely recommend a series of hospitals of only a few hundred beds, or whether it should agree to a different kind of institution—housing much larger numbers more simply—as provision for chronic patients who were already under detention in the almshouses, and not well cared for there.

The first proposition declared that it would be unwise to abandon all mechanical restraint. The statement was conservative and probably told less than was felt, for a quarter of a century later the supposed good results of mechanical restraint were asserted much more strongly. In 1851 some propositions on construction were formulated by Dr. Kirkbride of the Pennsylvania Hospital and were adopted unanimously. They set a limit of two hundred and fifty beds per hospital, with the purpose of keeping the number of patients within the scope of the superintendent's capacity for adequate knowledge and treatment of each patient. In those days the superintendent was personally responsible for everything that was done to and for the patient, and if he was a competent man this was a very admirable arrangement. Other propositions discussed what kind of site should be acquired and insisted that plans should be passed on by experts, that buildings should be sound and strong and should have at least eight ward units, each to include suitable utilities and adequate space for each patient; they dealt with offices and living rooms, with lighting, laundry, heating and ventilation, plumbing, floors; they required that the rooms for disturbed patients should be on only one side of a ten-foot corridor with windows affording pleasant views, that pleasure grounds should be surrounded by a wall. These were all very good principles to follow in that day, and many of them might well have more attention now. Hospitals built in accordance with these propositions were not costly and were comfortable and easy to administer.

Limitation on the size of a hospital has been the subject of continual debate, in the Association, in state bureaus, and in architects' offices. The limit originally proposed by the Association was raised to six hundred beds in the year 1866. The opinion of five of those voting had not changed, but the other nine were persuaded either from personal conviction or from their interpretation of the course of events that it would be better to accept as a maximum the size that Utica was soon to reach rather than leave the matter without a pronouncement.



DOROTHEA LYNDE DIX

In 1853 Dr. Kirkbride brought forward propositions regarding the organization of mental hospitals. The document in which these were presented accomplished much good, and several of its principles need to be reemphasized. In 1866 "elaborate and carefully framed resolutions" covering the care that should be furnished to several classes of mentally ill persons were adopted.

Several principles governing the handling of medico-legal problems were put to vote by the Association but were not called propositions. Following an accumulation of disagreeable incidents in various states, Dr. Isaac Ray offered a series of propositions on the legal relations of the insane. They were adopted in 1871.

In 1888 the whole situation was reviewed in a careful committee report.⁶¹ Dr. Godding had gathered the views of the older members of the Association, many of whom were happy to recall the benefits that had flowed from proclaiming the propositions of earlier days but who believed that newer schemes had been and should be adopted. In characterizing the propositions Dr. Godding remarked: "A dead letter as canons of authority, but as historic truth, as formulated methods, as the sincere utterance of men whose deeds kept ever in the van of their words, they are living still, and as such they will remain." A warm debate ensued, and the Association finally decided it was not necessary to reaffirm any of the older propositions, and that it was not necessary to adopt any new ones. After this action was taken the Association never put forth any set of standards under the title "propositions." But almost immediately it was called on to endorse—and did endorse—a project for full state care in New York, and other matters from time to time met the approval or disapproval of the Association. The formulation of a new set of standards did not come up again for years.

When mental institutions had won an accepted place in the social as well as political organization of every state, there was less ardent rhetoric in their behalf in the debates of the Association; but whenever institution work was broadened, or some way was found to do it better, the same fine note of satisfaction in a great job resounded forth. Thus there was strong praise for schools of nursing, occupational therapy, aftercare, treatment of general paresis. The whole mental hygiene movement may be viewed as one development of the work that was being carried on a hundred years ago by the founders of this Association. Organizations that have

⁶¹ *Am J Insanity*, XLV (1888), 137.

promoted better understanding of the prisoner, better management of the delinquent, better treatment of the deviatory child, better management of the nervous soldier, have been dependent in very large measure on the sound experience and the genuine, altruistic zeal of men whose primary work was in mental hospitals.

The National Committee for Mental Hygiene was founded in 1909 under the leadership of Clifford W. Beers, a young businessman who had recovered from a severe mental upset.⁶² He stands probably only second to Miss Dix in influence on bettering the care of the mentally ill. His methods were far different from hers, but he set in motion a powerful auxiliary to the forces that were working for progress in this field. When the National Committee was still young, it was granted by the Rockefeller Foundation considerable sums with which to finance surveys of mental hospitals. Since recommendations were requested in the hospitals surveyed, the whole subject of standards was again opened up. The leaders of the Committee were prominent members of the Association, and its first medical director, Thomas W. Salmon, had a keen understanding of hospital administration.

At the end of the first World War, in 1919, the Federal Government was responsible for the care of a considerable number of mental patients. As we have noted, contracts were placed for the care of many of them. To assist in speeding the work, a committee of members of the Association was called together by the National Committee for Mental Hygiene.⁶³ Members of this Committee became official consultants to governmental agencies and secured the promulgation of several standards essential for the correct treatment of the mentally ill veteran. Although not an official pronouncement of the Association, these standards were so helpful that in 1922 the Association set up a new Committee on Standards and Policies, with William L. Russell as chairman, to take up the whole subject afresh.⁶⁴ This committee obtained information about correct practice from institutions all over the United States and Canada and presented a series of nineteen standards which were adopted by the Association in 1926, after due publication and distribution among all the membership. A twentieth standard was added a few years later. These standards are

⁶² *Twenty Years of Mental Hygiene* (New York, American Foundation for Mental Hygiene, 1929), p. 9, see also the chapter in this volume, "Mental Hygiene," pp. 356-364.

⁶³ "Standards for Mental Hospitals," mimeographed by the National Committee for Mental Hygiene, December 8, 1919.

⁶⁴ W. W. Godding, *Am. J. Insanity*, XLV (1888), 137.

worthy successors of the original propositions; in them, some matters that were set forth at length in the earlier propositions are compressed, while many others that had developed in the then more than eighty years of the Association's existence are introduced.

What sort of institutions were these that now look so hoar and mellow? We find much about the details of their construction, we see cuts of their fine architectural lines, and we know the pronouncements of their superintendents on many matters; but we do not always find it easy to conjure up the atmosphere of an institution as it seemed to the patient. If diaries were kept by hospital workers, they seem not to have come to print. Those who have worked to improve the conditions under which the mentally ill are cared for not infrequently have written cheerful screeds which are correct so far as their own observations went but which overlook the fact that poor institutions—even wretched institutions—still exist. Psychiatrists sometimes have hazy ideas of how the hospitals in a contiguous state are run. Benjamin Rush in 1812 said that the period of cruelty and insensibility was passing away, he remarked truly that the clanging of chains and the noise of the whip were no longer heard in the cells of the Pennsylvania Hospital.⁶⁵ But in 1942 there were still a few chains in some institutions.

Fortunately it is not impossible to reconstruct the procedures of many years ago. Although the institutions of the period from 1840 to 1880 had some excellent points that are rarely seen at present and some defects that are less common today, in the main their best points are still our best points, and their very weaknesses are retained on a broader scale in many parts of the country.

On the credit side, these fine old buildings with their thick walls of brick and stone were usually comfortable places in which to live, either in summer or winter. The new institutions of eighty to a hundred years ago were not crowded: a definite capacity was set and but little exceeded, if at all. In this regard they were like the Veterans Hospitals of the present time, which provide for a definite number of patients and provide well, but do not accept a patient till his bed is ready. The patient on the waiting list of a mental hospital in 1860 might be cared for in the almshouse, of which the community was not fond but to which it was inured by custom; or he might wait in jail, as he still does in several states.

⁶⁵ Quoted by D Hack Tuke, *The Insane in the United States and Canada* (London, Lewis, 1885), p. 12

In the best hospitals of 1850, floor space was generously provided. This made the institutions much more comfortable for quiet patients than some of them are today. It also benefited the disturbed patients, since they had relatively more space in which to work off their feelings. Unhappily, as time went on this changed, and all over the land one finds two or even three beds in rooms that were intended for one, and beds up and down corridors whose builders never imagined that they would be occupied except in the daytime.

Ventilation in a considerable number of the early institutions was not good. Systems had been thoughtfully planned but were too often ineffective. For heating, stoves were used in some places, but because they were fire risks they fell under sharp criticism, and after being condemned by the Association they were all discarded.⁶⁶ In some of the earliest institutions (for example Worcester), air was heated centrally and conducted in huge flues to the ends of the buildings. Hot air is not a docile servant, and this system was soon supplanted by one in which steam was conveyed in pipes through all the buildings and used to heat air under every block. The hot air then rose through flues to each floor and was distributed through the rooms. In many buildings there were some rooms that had no heat except that which leaked in from the corridor, but better builders provided flues into every room. A vent supposedly removed the foul air. Sometimes the hot air was brought in at the bottom of the room and the exhaust was at the top, but in many places the standard system of introducing hot air at the top and withdrawing used air at the bottom of the room prevailed. Sometimes the architect planned the flues too small, these were either stopped up, or replaced, or left in their inadequacy. One important principle of physics was often overlooked—that wind sweeping fast across the cold-air intake will create such suction that air is drawn out of the building at the point where it is supposed to go in. Forced ventilation, effected by the installation of exhaust fans in attics, often was inadequate or got out of order. Many institutions therefore “suffered from too much heat and too little fresh air,” except during a storm when some sections of the buildings had neither hot nor fresh air. In 1853 Utica installed a forced draft that always worked; it was copied elsewhere.⁶⁷

Artificial light was usually supplied by lamps of some sort, but as late as 1884 the hospital at Jackson, Louisiana, used candles only.⁶⁸ Such light-

⁶⁶ *Am. J. Insanity*, XXIV (1867), 227.

⁶⁷ *Am. J. Insanity*, XXXIII (1877), 431.

⁶⁸ *Am. J. Insanity*, XLI (1884), 125, also, XLIII (1886), 391.

ing held perils, and in most places it was considered safer as well as more convenient to get people into bed early. Electricity was first installed in the 1880s.

Sanitation was like that of the neighborhood; in 1863 Williamsburg had neither urinals nor water closets nor proper sewage nor water supply.⁶⁹ The overflow of the Bloomingdale sewage tanks on Manhattan Island ran in a ditch for a quarter of a mile and became the water supply of a settlement of squatters, they protested when the flow was curtailed.⁷⁰ Differences in standards of upkeep seem to have been as pronounced then as now.

In 1851 Dr. Isaac Ray discussed pungently the reasons why many people felt antagonistic to the mental hospitals.⁷¹ In many cases a new patient was brought into a barren, cheerless compartment where nothing seemed homelike and where noise from other patients disturbed his rest. Hospital construction in this country was deteriorating, he said, and narrow dark halls, low ceilings, bare walls, and monotonous ranges of windows row upon row reminded one of a jail or factory. Compartments for most violent and refractory patients were constructed purely with a view to strength; they were often in a detached building, and disturbed patients when taken to them by day or by night were exposed to unpleasant comment from other patients and sometimes to peril of illness from exposure. Neighbors and institution servants were allowed to go through the wards. Patients were allowed to range around the institution unsupervised. Untrained employees without special qualifications were put in charge of wards of patients, with no superior except the head of the institution. Frequently, an attendant was in complete charge of perhaps twenty patients whom he left to themselves while he ran errands. There was a dearth of supervisors.

Dr. Ray's strictures were probably just, for in the same period Dr. Bell considered it a bad arrangement to have a night watch because it kept patients in such an uproar that they imagined themselves sick and sent for the doctor at all hours.⁷² In 1851 Miss Dix, commenting on conditions at Bloomingdale Hospital, complained of the crowding, of insufficient heat and lack of bathrooms and sinks in the lodges (small buildings for the

⁶⁹ "American Medical Times," *Am J Insanity*, XX (1863), 244

⁷⁰ D. T. Brown, *Am J Insanity*, XX (1864), 276

⁷¹ *Am J Insanity*, IX (1852), 36-65

⁷² *Am J Insanity*, X (1853), 76

disturbed), of the lack of a night watch in either lodge, of difficult service of food, of the lack of a supervisor.⁷³

Evidently the ornamentation of the wards a century ago varied as much as it does now. In many cases the walls were bare, but Northampton⁷⁴ displayed 1,308 pictures. Some wards had carpets. Furniture was probably adequate in most hospitals, but in some the back wards had insufficient seats. Dr. Tucker said of Taunton in 1885, "The corridors are furnished, for the most part, with heavy wooden settees. There are a few chairs and rocking-chairs about, and these, I remarked, were in constant possession by the attendants."⁷⁵ As one got further away from the administrative center one was likely to find less ornamentation, fewer comfortable chairs, bare dining rooms, and other evidences of an effort to save expense by banishing anything that might be broken or seriously marred, rather than an effort to make disturbed patients less disturbed by giving them greater comfort. But hospitals in those days differed in these regards as they do now. Patients who had bedrooms sometimes had bedroom furniture, depending on that part of the hospital in which they dwelt. Some institutions had wooden beds, but when iron beds became available they were more popular, apparently for sanitary reasons. In some places the mattresses, stuffed with corn husks or straw, must have been lumpy. Sometimes they were thin. Dining rooms were simple, one for each ward. Knives and forks were supplied in the better hospitals.⁷⁶

Medical attention was expected to be good, and many of the early superintendents were outstanding practitioners of internal medicine. The early superintendent knew all his patients and knew them well. He not only watched their physical condition, but he entered into their hopes, their fears, their frustrations. It would be strange indeed if some of the good results that made cheerful the hard task of hospital administrators in those early days did not spring from the personal efforts of the astute and experienced men at the head of the institutions, in aiding the patient to understand himself better and meet the difficulties of life, and particularly the difficulties of his own temperament, more successfully.

Assistants came fresh from school or internship, or from private practice. They were all men until 1872, when a woman physician was ap-

⁷³ Original letter framed at New York Hospital, Westchester Division

⁷⁴ Nineteenth Annual Report, 1874. Quoted in *Am J Insanity*, XXXII (1875), 82.

⁷⁵ G. A. Tucker, *Lunacy in Many Lands* (Sydney, C. Potter, 1887), p. 325

⁷⁶ *Am J Insanity*, I (1844), 7; also, Charles Dickens, *American Notes* (New York, Frank F. Lovell Co., 1883), p. 628

pointed at Augusta, Maine.⁷⁷ For cooperative patients nursing was no worse but probably better than was ordinarily had in the community. The ratio of attendants to patients ranged from 1 to 8 in the Pennsylvania Hospital to 1 to 25 or 30 at Stockton.⁷⁸ In 1900 an "ordinary" ratio was 1 to 12.⁷⁹

Food was probably plentiful in the early institutions. Most of them had productive farms, and good cooks did not command the relatively high salary that they do now. It is likely that institution diets were marked by sameness (in 1859 some patients in Ohio contracted scurvy from their limited diet), but probably there was less of the lack of flavor and insipidity that is charged against food in poor institutions today; it is easier to cook for two hundred than for two thousand and make the food taste home-cooked. The situation was also more intimate, and patients were not so far separated from those preparing the food but that a complaint would carry weight. Then too, the head of the institution expected to make rounds every day, and anyone who has lived in an institution knows the influence on cooking of the presence of the superintendent in the ward during mealtime. Dr. Spratling averred in 1898 that "few officers of asylums for the insane have really intelligently studied dietaries to suit the physical needs of their patients."⁸⁰

In many respects hospital life was very comfortable for adaptable patients. In 1863, when Utica had five hundred and twenty-eight beds, no fewer than three hundred and forty-one were in single rooms.⁸¹ Back in 1850 patients made many fancy articles for sale, and some of the money bought musical instruments and also built a greenhouse. Most but not all institutions had chapel service on Sunday. Hartford Retreat had a resident chaplain.⁸² Dances and other amusements were available: as late as 1913 a committee of the Association, reporting on information from over 60 per cent of the existing hospitals, said that recreation in most of them was limited to the dance and an occasional picnic or motion picture.⁸³ That was in great contrast to the program of a few outstanding institutions. In older days the Pennsylvania and Northampton institutions led in recreational activity. In one year at Northampton only eighteen nights

⁷⁷ B. T. Sanborn, *Transactions of the Am Medico-Psychological Assn*, XV (1908), 354.

⁷⁸ Kirkbride, *op. cit.*, p. 212, also, Annual report, Stockton (California) State Hospital, 1863

⁷⁹ J. G. Rogers, *Transactions of the Am Medico-Psychological Assn*, VII (1900), 77

⁸⁰ *Am J Insanity*, LV (1898), 313

⁸¹ Joseph Workman, *Am J Insanity*, XXI (1865), 442

⁸² *Am J Insanity*, XIV (1858), 370-375

⁸³ *Am J Insanity*, LXX (1913), 250

were without an entertaining or informative session; Dr. Earle himself lectured to his patients on physics, diseases of the brain, and many other topics. And Dr. Kirkbride reported that not a night had been missed in one department of the Pennsylvania Hospital in several years, and few in the other, during nine months of each year.⁸⁴ The nearest counterpart in recent times is the recreational program of the Jacksonville State Hospital and The Lincoln State School, both in Illinois.

The patients at Utica worked up a celebration of Pinel's birthday in 1846, they heard hymns by a lawyer and a prayer by the chaplain, a eulogy and recitations were given by patients, and letters from the superintendents of other institutions were read.⁸⁵ In 1849 the superintendent used to conduct patients through the hospital museum, where there were coins, war mementoes, and the head of an Egyptian mummy. A debating society was maintained. Ninepins were available in every hall. The ladies' annual exhibition included tableaux, a duet, a two-act play, a Scotch reel, and the singing of "Hail Cōlumbia" led by the asylum brass band. Fifty newspapers were accumulated from all parts of the country, and some halls had a daily paper. In 1851 three parties of patients went to Niagara Falls. The most ambitious picnic on record was arranged by the Columbus State Hospital in 1894; a special train took five hundred patients a hundred miles to Sandusky, whence they had a twenty-mile cruise on Lake Erie.⁸⁶

The hours of activity and hours of rest both began early, a hundred years ago. Attendants at Utica rose at 4:30 in summer and 5:30 in winter.⁸⁷ The doors of the patients' rooms were opened and housework started. Breakfast was served an hour and a half after rising. In the better hospitals there was plenty of food, and in the poor hospitals the quantity seems to have met little criticism, but the quality and variety received less attention than they should, so it was said. After breakfast the working patients were taken out to the farm or the sewing room, or, in some hospitals, to sports or school. Physicians made rounds at ten o'clock. Physical training was given attention in some of the best institutions, at least as far back as Amariah Brigham's day. It was said to be "a general movement" in 1889.⁸⁸ Still, so little was it organized that when trained physical educators

⁸⁴ Annual report of the Pennsylvania Hospital for the Insane, 1882. Noted in *Am J Insanity*, XL (1884), 235.

⁸⁵ *Am J. Insanity*, III (1846), 78-89

⁸⁶ *Am. J Insanity*, LI (1894), 271, 272.

⁸⁷ *Am. J Insanity*, I (1844), 7

⁸⁸ Walter Channing, "Physical Education of Children," *Am J Insanity*, XLVIII (1892), 311

were put in charge of such activities in the second decade of the present century, it seemed to most people like an innovation. The first hospital gymnasium was erected at the Friends Hospital in Philadelphia in 1889.⁸⁹

Unhappily the general reputation of American institutions regarding the employment of patients has been low. In some places 60 or 70 per cent of the patients were said to be doing something useful and of more importance than ward work, but this has never been general and occurs too infrequently. Back in 1862 Isaac Ray said that the amount of labor obtained in New England institutions was diminishing.⁹⁰ Some fugitive figures came from the six New York State hospitals in 1882.⁹¹ The proportion of men employed ranged from 23.63 per cent at Middletown to 65.09 per cent at Hudson River. For the women the figures ran from 12.54 per cent at Middletown to 51.38 per cent at Utica. A committee of the Association was informed in 1913 that from the institutions reporting (over 60 per cent of them), 40 to 60 per cent of the patients were employed routinely.⁹² Figures obtained in 1941-43 show that the Connecticut State Hospital employed 49.6 per cent, Harlem Valley 28.9 per cent, and Elgin 47.1 per cent. Increasing age of patients, crowding of wards, and lassitude of program affect the figures.

There has also been considerable variation in practice regarding the number of patients who were taken out to walk, unless they went walking to their jobs; in many American hospitals it has been the practice to let patients sit indoors days, weeks, and even months, until the outdoor weather happened to be perfect in stillness, temperature, and sunshine.

Here we face the question, how have disturbed patients been managed? Obviously something must be done about the problems created by restlessness and irascibility. If the patients are crowded together, do little work and get little exercise, some repressive program is inevitable.

A hundred years ago, the theory of management of the mentally ill in this country was still very largely that set forth in vivid detail around the turn of the century by Benjamin Rush.⁹³ He was convinced that the physician must establish domination over his patient; in this he probably reflected the sentiment of the times. Bloodletting must have quieted many a

⁸⁹ Hurd, *op cit.*, III, 449

⁹⁰ *Am. J. Insanity*, XIX (1862), 60

⁹¹ Tenth Annual Report of New York State Commissioner in Lunacy, abstracted in *Am. J. Insanity*, XL (1884), 494

⁹² *Am. J. Insanity*, LXX (1913), 249

⁹³ Edward Cowles, *Am. J. Insanity*, LI (1894), 14

stormy soul, and was still practiced in Norristown in 1884.⁶⁴ Violent emesis and purgation were considered effective. The somewhat startling advocacy of the use of mechanical restraint set forth in early discussions in the *American Journal of Insanity* was not due alone to Rush's influence, which, nevertheless, would probably have been thrown on that side of the question. The supposedly good results of mechanical restraint were extolled by some and controverted by others who said that the number of untidy, restless, aggressive, and noisy patients in American institutions was due to the way they were handled.

The subject was not considered important enough to call for controlled studies of how restraint was used or how much was used, or what the effects were. Dr. Woodward wrote in 1845 that restraint was rarely used to any great extent in this country.⁶⁵ Perhaps its use increased in the next two decades, but it seems probable that in the seventies and eighties a considerable decrease was effected. Dr. Earle, after he became better acquainted with the insane, found that not so much restraint was needed.⁶⁶ Drs. Earle, Kirkbride, and Ray reported in 1884 that their institutions used little restraint. The very next year, a Kentucky institution got unpleasant notoriety under a political superintendent who used a lot of restraint without controlling the authority for ordering it.⁶⁷ Dr. Bucknill's work on American asylums referred to the "most unfortunate and unhappy resistance" of the superintendents to the abolition of mechanical restraint as their "great stumbling block."⁶⁸ In a discussion of the problem an assistant from Georgia asserted that it was not used enough in his institution. Some superintendents believed that restraint was an unfortunate but inevitable measure in the management of excited patients. Others believed that restraint had great healing virtues. Many seem to have been middle-of-the-roaders who did not feel very strongly about the desirability of restraint but who objected to propaganda against it. They asserted that much of the campaign was pretense and that undesirable substitutes for restraint were used, such as attendants' holding struggling patients for long periods, and administration of large amounts of chemical sedatives.

⁶⁴ Tuke, *op. cit.*, p. 157.

⁶⁵ Annual report of Lunatic Hospital, Worcester, 1845. Quoted by Stearns, *Am J Insanity*, XLI (1884), 33.

⁶⁶ *Loc. cit.*

⁶⁷ *Am J Insanity*, XLI (1884), 115.

⁶⁸ J. C. Bucknill, *Notes on Asylums for the Insane in America* (London, Churchill, 1876), p. 67. See pp. 111-112.

Theory and practice did not always coincide. Dr. Bucknill of England gave an illuminating example in Dr. Kirkbride's attitude.⁹⁹ Dr. Kirkbride had said that he was a believer in the use of restraint, and quite in disagreement with the nonrestraint school; yet in the Pennsylvania Hospital Bucknill noticed that no one was in restraint. On the other side there were those who pushed their practice in the direction of restraining anyone who was at all refractory.

The types of apparatus used for mechanical restraint are set forth in hospital reports and other writings. They covered about the same range as those that are used today. One structure is, however, at present hard to find—the so-called Utica crib. The first type was described in the *Annales Médico-psychologiques* as Aubanel's restraining bed; in 1845 Dr. Brigham had one made at Utica.¹⁰⁰ A similar bed, called a crib, was used at Bethlem (in London) before 1852. In 1854 the Aubanel bed was abandoned at Utica and one much like the Bethlem affair was substituted. A few similar structures survive in distant parts of the country, but they are usually made of iron instead of wood. Another apparatus that seems to have disappeared long ago is Dr. Wyman's bed strap.¹⁰¹ Apparently this was a crisscross arrangement of canvas straps to keep patients in bed; it was passed around the body and buttoned at the back, and the four ends were passed under the bed and buckled. It was considered cooler than a camisole.

Utica had a one-story ward for disturbed men who were kept in restraint all day. They were seated in large and fairly comfortable chairs and fastened there. The hands were confined to the chair arms and the knees could not be raised very high, leaving an opportunity merely to swing the feet back and forth, on the floor of this ward are slight depressions worn by swinging feet prior to 1890. Dr. Chapin of the Pennsylvania Hospital said in 1889:

Many in this assemblage may recall the long straight corridors of our asylums and hospitals in their earlier days, the walls, destitute of any ornament or pictures, scantily furnished, cheerless, monotonous and uninviting. Some here present do not forget the rows of chairs securely fastened to the floors, as was every article of furniture, in which were restrained such patients as were turbulent, nor the din and confusion of what were properly called the "Noisy Wards."¹⁰²

⁹⁹ *Ibid.*, pp. 4, 5

¹⁰⁰ *Am J Insanity*, III (1846), 185, 186, also XXXIV (1878), 515, 516

¹⁰¹ Personal communication, R. H. Hutchings, 1942

¹⁰² *Am J Insanity*, XLVI (1889), 11

In many institutions in these United States there are today restraint sheets, camisoles, belts attached to cuffs, leather armlets, anklets of leather with a cross chain, and restraint chairs. Other institutions do not use mechanical restraint except to protect the dressing on a fracture or a wound from the restless fingers of an unappreciative patient.

We know two instances in which a superintendent dramatized his disapproval of mechanical restraint by burning the apparatus. When Dr. Fletcher of Indiana did this in 1885, the *Journal* was not very favorably impressed, but when Dr. Blumer repeated the performance at Utica in 1887 the editorial policy of the magazine had come under his control.¹⁰⁸

Seclusion of a patient behind a locked door has not been so much debated by the Association as has restraint. Dr. Kirkbride said that at night patients were commonly locked in their rooms, and hundreds of them are thus locked at the present time.¹⁰⁴ Hundreds more are in rooms whose doors have no handle on the inside. A simple device like a towel or a newspaper between the edge of the door and the jamb is quite sufficient to keep most patients from getting out. Padded cells have never been highly regarded in this country.

For many years admission to mental hospitals was very simply arranged; a request from a poor-officer or a relative was sufficient. Then came a period of litigation, with charges of misconduct in detaining persons improperly held. Institutional men took the lead in getting the passage of commitment laws; it was necessary for their own protection. Unhappily these laws sometimes made it harder for a patient to enter a hospital. To meet this difficulty at least in part the admission of patients on their own application was later permitted. Massachusetts was a pioneer in this matter, accepting voluntary patients in 1881.¹⁰⁶ The measure met strong opposition in some states, however; some superintendents objected to any arrangement by which their control of the lives of their patients would be rendered less complete. Even the New York State Commission in Lunacy was very dubious about it.¹⁰⁶ But Peoria in one recent year admitted 56 per cent of its patients on their own application.

Opposition was also expressed to the idea of letting patients leave the

¹⁰⁸ *Am. J. Insanity*, XLI (1884), 253, also R. H. Hutchings, *Am. J. Psychiatry*, XCVII (1941), 414

¹⁰⁴ Kirkbride, *op. cit.*, p. 216

¹⁰⁶ Personal communication, Clifton T. Perkins, Commissioner, Department of Mental Health, The Commonwealth of Massachusetts, September, 1943

¹⁰⁶ State Commission in Lunacy, Second Annual Report, 1891, pp. 129-131

hospital and yet remain on the books so that they could come back without formality. This laudable procedure seems to have started at Staunton, Virginia.¹⁰⁷ In 1859 a new superintendent at Toledo abolished its "probationary list" of patients on parole.¹⁰⁸ The procedure complicated the records, the superintendent said, and the rooms had to be held for the patients while they were out, which gave a false impression of how much space was available.

It is instructive to see how mental institutions have looked to outsiders, particularly those who were experienced in the care of the mentally ill. Visitors from England and the Continent came to America occasionally and were courteous but firm in their criticism of American methods. Occasionally a person from one section of the country spoke his mind about conditions in another section, and there are also a few illuminating statements from professional neighbors.

The first story comes from Charles Dickens, who was here on a lecture tour in 1842. His observations are recorded in his *American Notes*.¹⁰⁹ Dickens visited two city institutions, one in Boston and one in New York. He was much pleased by the first and much distressed by the second. He said that the institution at South Boston was admirably conducted. Dr. Stedman dined with his patients, every one of whom had a knife and fork. Among the patients, for whom work and recreation (including a weekly ball) were provided, cheerfulness, tranquility, and immense politeness and good breeding were remarked. The institution on an island in New York was not finished but was already of considerable size and remarkable for a spacious and elegant staircase.¹¹⁰ Lack of cleanliness, a lounging, listless air, and the interference of political parties were deprecated by Dickens. This Blackwell's Island institution came in for sharp criticism from the Association six years later and was said to have undergone very marked improvement in the next three years.¹¹¹

J. Henry Tuke, a great-grandson of William Tuke who founded the York Retreat in 1792, visited this continent in 1845 and was troubled by much that he saw. The Lunatic Asylum in Toronto, for instance, was "one of the most painful and distressing places" he ever visited.¹¹² Orig-

¹⁰⁷ Hurd, *op cit*, III, 728

¹⁰⁸ Annual report, 1859. Quoted in *Am J Insanity*, XVII (1860), 88, 89

¹⁰⁹ Dickens, *op cit*, pp 626-629

¹¹⁰ *Ibid.*, pp 671-672.

¹¹¹ *Am J Insanity*, V (1848), 89-91, also, IX (1852), 72

¹¹² Tuke, *op. cit*, p 215

nally intended for a prison, it was dark, and the faces of the seventy patients showed misery, starvation, and suffering. The doctor in charge pursued a system of constant cupping, bleeding, blistering, and purging the patients, giving them the smallest quantity and poorest quality of food; no meat was allowed. This institution happily ceased to exist, and was replaced by the hospital on Queen Street.

At the meeting of the Association in Boston in 1855, some views of Dr. Galt of Virginia which had been published in the *American Journal of the Medical Sciences* provoked a warm discussion.¹¹³ Galt had said that New England institutions looked like mere prison houses, and that ground privileges were denied to great numbers of patients who should have them. His intimation that the heads of the most richly endowed asylums neglected their patients in order to tinker with gas pipes and study architecture was vigorously resented. Out of the discussion one gleans that a number of superintendents had been finding fault with their buildings, for two years the institutions at Worcester and Utica had been ripping out some small, dark seclusion rooms to make comfortable quarters. Indeed, according to its own trustees Worcester had been a dismal place, with forty-eight strong rooms that were almost constantly in use.

In 1870 Dr. E. T. Wilkins was appointed commissioner in lunacy for the State of California, to visit and report on institutions in this country and Europe.¹¹⁴ Altogether he saw one hundred and forty-nine institutions, of which forty-five were in this country and one in Canada. In one place or another he found various practices to recommend: adequate workshops, a gymnasium for men, a calistheneum for women, various ball games, riding a car on a circular railroad, courses of instruction in a well-furnished schoolroom, reading aloud by teachers to patients in the excited wards, well-selected libraries, inspection and collection of curiosities, use of musical instruments, care of domestic animals, carriage riding, interesting expeditions, musical entertainment, and courses of lectures. Wilkins said that in most of the asylums in the United States the dance is added to this list or substituted for some other item. The ratio of attendants to patients varied from 1 to 3 in a private institution at Litchfield, Connecticut, to 1 to 25 at Longview, Cincinnati. California was the only state that had never rejected a single person who sought admission to a mental hospital, but in 1871 fifty-nine were admitted at Staunton and one

¹¹³ *Am. J. Insanity*, XI (1855), 353, 354; also, XII (1856), 42-48.

¹¹⁴ E. T. Wilkins, *Insanity and Insane Asylums, a Report* (Sacramento, T. A. Springer, 1872).

hundred and forty-nine rejected; one hundred and fifty-five were rejected at Kalamazoo, and one hundred and fifty at Dix Hill, the Indiana institution could accommodate no more than one third of its applicants.¹¹⁵ Wilkins said that venesection was going out of favor and leeches were employed frequently. Purgatives were used liberally and emetics fairly often. The stimulants preferred were ether, ammonia, strong beer, liquor, and wine. In some places hot and cold baths were used, but not so freely as in the institutions of several European countries.¹¹⁶

In 1875 Dr. John Charles Bucknill, the prominent English psychiatrist, visited ten hospitals in the United States and three in Canada, two schools for idiot children and six institutions for habitual drunkards.¹¹⁷ His findings were published in the London *Lancet*. He thought that the lack of outdoor exercise here was lamentable, and complained of the overdried and overheated air and the lack of an appearance of health among the patients. All this, he said, was not confined to mental institutions but was the habit of the country. Of Americans he remarked, "Indoors they coddle themselves with cooked air, and out they do not care to budge, at least not for pleasure. When duty or business withdraws them from the stove atmosphere of the house, they encase themselves in great coats, in bright, blessed weather, when an average Englishman would revel in the fresh delicious air."

The Pennsylvania Hospital he considered quite like the best in England.¹¹⁸ He also approved the schools for defectives at Boston and Syracuse. The original building at Utica with its imposing Doric portico of granite he considered lasting testimony of the liberal ideas of its earliest constructors, and he approved the glazed rooms at the ends of the wards. At Utica he saw capital amateur theatricals. He spoke well of several institutions, while condemning others as thoroughly discreditable. One of the unsatisfactory conditions was the sight of eight apparently quiet patients in strait-waistcoats at St. Elizabeths.¹¹⁹ At McLean Bucknill disliked the "lodge wards" and the pavilions for wealthy tranquil inmates who were living too much to themselves. Blockley had accommodation for five hundred patients and a census of eleven hundred and thirty; and he noticed there strait-waistcoats, turbulence, no exercising grounds, and no occupa-

¹¹⁵ *Ibid*, p. 209

¹¹⁶ *Ibid*, pp. 178, 213

¹¹⁷ Bucknill, *op cit*, pp. 2, 3, 10-14

¹¹⁸ *Ibid*, pp. 4, 24-25, 36-38

¹¹⁹ *Ibid*, pp. 8-9, 34, 42-43, 47-53

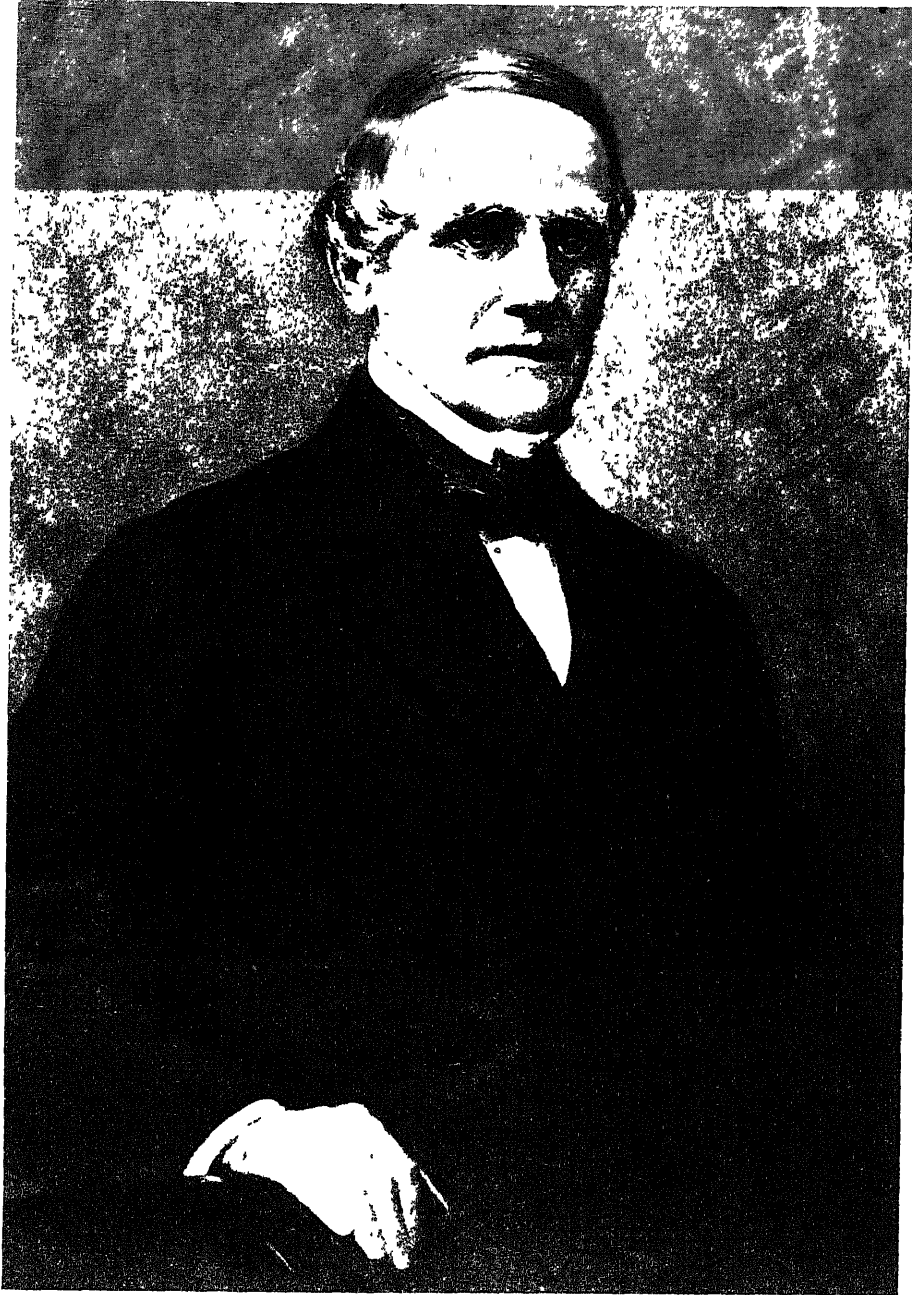
tion; "lodge wards" for nineteen women patients held sixty-five. The institution on Ward's Island was run by a warden, was crowded, dismal, provided no occupation, no amusement; patients were ill cared for, badly clad, and had poor nursing, but the cost was only \$1.30 per week, contrasting with \$4.50 at Utica. The women on Blackwell's Island were miserably overcrowded but better clad than the men on Ward's Island, and better nursed; in many cases they were occupied with needlework. In Montreal the patients were in what had been a jail and cavalry barracks and had never been visited by a medical officer, but no one was in restraint or seclusion.¹²⁰ At Beaufort Asylum there was a mad medley in the yard. Bucknill was surprised at the Association's debate on curtailing the correspondence of patients, as well as at the opposition to patients' leave of absence and to the discharge of anyone that was uncured.¹²¹ He deplored the American devotion to mechanical restraint; 10 per cent of the patients at Indianapolis and 2 per cent in Georgia were thus restrained, but there were none at the moment at the Pennsylvania Hospital or Bloomingdale. He attributed the popular distrust of asylum management in part to the use of mechanical restraint, and in earnest rhetoric urged the superintendents to take another course. Eleven years after the appearance of Bucknill's work, Dr. Grissom wrote a long and acid reply to the charges.

Dr. Daniel Hack Tuke was another great-grandson of William Tuke. In 1884 he visited the institutions of the North Atlantic seaboard as far south as the District of Columbia, and also those of Illinois and Wisconsin; altogether he saw forty. He spoke highly of the superintendents as a class.¹²² He commented that there were proportionately more physicians in England, better paid, and in more instances married. He thought America had been wiser than England in avoiding the construction of so many very large asylums. Patients were better fed, better and more warmly housed. Individual comforts, likes and dislikes received more recognition and attention than in British institutions, but most American galleries were bare and unfurnished. Dr. Tuke liked the arrangements in Wisconsin. He noted the frequent evening entertainments at the hospitals at Warren and Northampton. He found that the number of patients in asylums in 1880 was 40,992, of whom 2,242 (5.4 per cent) were in restraint. The details on apparatus were camisole, 887; muffs, 526;

¹²⁰ *Ibid*, pp. 55-62

¹²¹ *Ibid*, pp. 66-88

¹²² Tuke, *op cit*, pp. 53, 54, 65, 84, 89, 93, 94, 109



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strapped to bench, 439; handcuffs, 147, ball and chain, 21; crib-bed, 111; type not stated, 111.¹²³ In an otherwise very good institution he had counted 50 cribs. At the other extreme was Bloomingdale, where in ten months only two men had been restrained and no women for two years. He thought the ball and chain must be in use in some southern or far western institutions. Dr. Gray at Utica said that he never used seclusion, but there was evidence of its use in many asylums to as great an extent as in Britain. The only padded room was at Danvers.

The employment figures follow: Utica, 35 per cent of the men, nearly 38 per cent of the women, Willard, 801 out of 1,758; Worcester, 38 per cent; Ward's Island, 34 per cent. On Ward's Island, 1,154 out of 1,494 went out for exercise. These figures contrasted unfavorably with Sussex in England, where 66 per cent of the men were employed, exclusive of ward cleaners, and Brookwood, also in England, where out of 318 men 229 were employed. Dr. Tuke approved of staff appointments for women physicians and of the training school for nurses at McLean Hospital.¹²⁴ He thought, however, that placing female nurses on the male wards at McLean must add greatly to the anxiety of the superintendent. Inspection was weak except in a few large states.

Like other English visitors, Dr. Tuke seems to have criticized Canadian institutions more freely than those in the United States. Speaking of Canada he said, "In the course of seven-and-thirty years I have visited a large number of asylums in Europe, but I have rarely, if ever, seen anything more depressing than the condition of the patients in those portions of the asylum at Longue Pointe to which I now refer."¹²⁵ Again, "Into this human menagerie, what ray of hope can ever enter?" Dr. Tuke made a strong impression on the medical profession. The evils of the contract system in Quebec nevertheless were not abolished, but in Montreal a new institution was started, the Protestant Hospital for the Insane, which was required by its charter to spend any profits for the benefit of its patients.

Dr. Hervey B. Wilbur was himself the superintendent of the school for defectives at Syracuse. He was an able student of brain functions and a good writer, and he always commanded a hearing. His unfavorable though not entirely unjustified opinion of mental hospital management may have been influenced by lack of experience with the mentally ill. In 1876 he presented a paper at a conference of charities at Saratoga

¹²³ Tuke, *op cit.*, pp 54, 55, 57, 62-64, 93

¹²⁴ *Ibid*, pp. 93, 114.

¹²⁵ *Ibid*, pp 193, 195.

Springs.¹²⁶ He criticized the hospital heads sharply—almost bitterly—for their objection to supervision. He said that recently erected asylums showed an extravagance of outlay and an unfitness of structure that could not be paralleled elsewhere, trustees made only perfunctory inspections, superintendents were often selected through social or political consideration or some species of favoritism; they were loaded down with an accumulation of duties and responsibilities. Besides his regular duties, a superintendent might frequently be a witness in court and have also a large and lucrative consultation practice. In many institutions the care of patients was left to assistants with very little experience. The superintendents were likely to become timid, overcautious, and content with a low measure of achievement. They felt safer when most of the patients were under lock and key. They did not trust their patients to labor in various occupations as was done in European countries.

A most extensive survey of mental hospitals was made by Dr. George A. Tucker of Australia, who published his *Lunacy in Many Lands* as a government report in 1885. He had had considerable experience, particularly in a private institution. He does not always express a flat opinion, but one who reads his volume of 1,564 pages, much of it in fine type, comes to know very definitely what standards Dr. Tucker preferred. In America he saw things that were not only unsatisfactory but also reprehensible. He had a keen eye for mechanical restraint.¹²⁷

Cages, iron chains, handcuffs, hobbles, straps, crib beds, and fixed chairs are common modes of restraint for patients, who being afforded no means of occupation or diversion for mind or body, naturally become noisy, and troublesome. The bath, either shower or immersion, is a favourite means of tranquilizing excited patients. In the cupboard showerbath the patient is subjected to a continuous downpour of water, and this, in some cases, as a punishment at the option of the attendants, without the sanction of a medical officer. In the covered hot bath, the head alone protruding, the patient is confined, unable to move, from one to twelve hours at a time, and in many instances unattended, with the water at a temperature of 35 degrees of Centigrade, and often with cold water dripping on the head. This, I have been gravely but rather needlessly informed, was not adopted as medical means of improving the patient, but simply to quiet and subdue him for the time being.

In one institution I saw 215 women in various modes of restraint—camisoles, wristlets, straps, &c.—secured upright to racks around the dayrooms. In another there were forty-three women in box beds, ironed hand and foot, and extended in spread-eagle fashion, at 3 in the afternoon.

¹²⁶ Wilbur, *Buildings for the Insane* (Boston, A. J. Wright, 1877)

¹²⁷ Tucker, *op cit*, pp. 16, 50, 77, 99, 348, 349, 446, 461, 507.

At St. Peter Dr. Tucker saw more restraint than in any other one asylum. Several patients were without shoes or stockings, and some had frost-bitten toes. This was not the universal situation. Alabama, Columbus, and Norristown had no restraint, and Ward's Island only three patients in restraint and one in seclusion. Connecticut used it rarely, Colorado only a little.

At Austin the whole staff from top to bottom had recently been changed.¹²⁸ Patients were in a miserable condition of intense cold, several without shoes or stockings and very scantily clad. Many were crying bitterly on account of the cold. No attendant was to be seen. At Topeka everything was in good order, the patients tidy and quiet, "Yet, with all the neatness and obvious comfort, there was an air of depression about the place. There is no life, and the stranger is struck with a want of cheerfulness in the faces of the inmates."¹²⁹ Dr. Tucker saw no means of amusement, and the patients were listlessly sitting or walking about. Utica's back wards were not pleasing. There were thirty-five cribs. Provision for employment of patients in this asylum was "comparatively excellent; absolutely it was not worthy of as much praise." One superintendent never allowed his female patients outside the wards, for fear that they would be degraded and demoralized by sunburn.¹³⁰ Dr. Tucker disliked having the criminal insane mix with other patients, but when he found sixty-six without occupation or amusement, he thought a jail would be an improvement for them.

"Except in private Asylums," he said, "in no part of the world have I found the handsome furniture and general elegant arrangements of the American States Asylums; but it is noteworthy that, with few exceptions, this remark applies to the front wards, the back wards being in this respect neglected, and in many cases nearly void of furniture."¹³¹ Happily there were exceptions. At Danvers the refractory wards showed much the same appearance as others, and although less expensively furnished were comfortable.¹³² There were pictures, flowers, singing birds, and other articles about, "which make the back wards of this Hospital equal to the best wards of many Asylums I have seen." He noted also at Danvers that the female attendants wore caps and aprons and were actually attending to

¹²⁸ *Ibid*, pp. 538, 539.

¹²⁹ *Ibid*, pp. 249, 443.

¹³⁰ *Ibid.*, pp. 5, 9, 337-339.

¹³¹ *Ibid*, p. 5

¹³² *Ibid*, pp. 306, 317, 380, 391, 463, 629, 630, 636.

their patients. The ratio of attendants to patients was 1 to 10. The institution at Hamilton made a pleasant impression, even the refractory wards. So did the Quebec Lunatic Asylum. Dr. Tucker liked Pontiac and Auburn and the humanitarian ideas at Columbus. Blackwell's Island now had two graduate nurses, patients walking twice a day, and calisthenics. The attendants in Illinois were of a superior class, and to this fact Dr. Tucker attributed the better management of many of the wards.¹⁸³ He praised the institution at Lincoln. Wherever a woman physician was employed he found greater order prevailing in the wards.¹⁸⁴ In a hospital where female attendants occupied rooms in the male wards, as when the wife of a senior attendant took her share in the supervision of male wards, cleanliness, order, and better morale were noted. Dr. Tucker's magnificent survey was probably but little circulated in this country and seems to have had only casual mention by the Association.

Every hospital is held in gratitude by some family, many have received valuable gifts, and legacies have been left to several. In three instances the legacies were permanent funds which are fruitful to the present time. These are the institutions at Concord, New Hampshire; Elgin, Illinois; and Lexington, Kentucky.

Combinations of public and private money often seem to accomplish more than funds from either source alone. Certainly the patients of these three hospitals have benefited very much from the income of these funds. It has turned out that entertainment and equipment which at first could be obtained only from these endowments were later recognized as suitable and could be purchased from appropriations. Such experience parallels what came out of the pioneer work of the corporate institutions on foundations, where experiment has shown the value of measures that at first sight would look extravagant for a public hospital.

Weir Mitchell in his jubilee address in 1894 criticized the hospital men sharply on the grounds of their professional isolation.¹⁸⁵ There was solid basis for his position, but he probably did not know of certain movements. Back in 1875 some Massachusetts superintendents had founded the New England Psychological Association, which still flourishes as the New England Society of Psychiatry. In 1893 Dr. Adolf Meyer brought about the founding of an association of assistant physicians in the Middle

¹⁸³ *Ibid.*, p. 22, 160

¹⁸⁴ *Ibid.*, pp. 21, 318.

¹⁸⁵ Address before the 50th Annual Meeting, *J. Nerv. and Ment. Dis.*, XXI (1894), 413-437, see also the chapter in this volume, "A Century of Psychiatric Research in America," pp. 167-168

States, which held meetings for a number of years.¹³⁶ There is now a similar association in Illinois. In 1894 the Binghamton State Hospital Society of Comparative Psychiatry began to hold biweekly meetings.

Wherever Dr. Meyer worked, he organized his hospital staff into a discussion group. In later years in the New York service, he developed inter-hospital conferences. An outgrowth was the formation in 1908, by the staffs of the Pathological Institute and the Manhattan State Hospital, of the "Ward's Island Psychiatric Society." Now there is a long list of state and regional societies, including both hospital physicians and their colleagues in private practice.

It is true that around the turn of the century many assistant physicians felt isolated. This had not been the case everywhere. John P. Gray, superintendent at Utica from 1854 to 1886, was the leading consultant in internal medicine in his section of central New York. When a new assistant brought the first stethoscope to that region, Dr. Gray took him on many consultation trips, pleased to have the advantage of the new instrument of precision.¹³⁷ Not every superintendent was in so great demand as Dr. Gray, and perhaps some were less generous in sharing calls for consultation. The situation was further bettered when outpatient clinics were established.

That sound and thorough clinical work was not prevalent even in some good hospitals before the turn of the century can hardly be doubted.¹³⁸ The period from 1900 to 1920 brought a great advance in this matter.

Mentally ill criminals form a particularly unattractive group of human beings. Mankind generally dislikes criminals and fears them. Mankind is too likely to fear and, therefore, to dislike its mentally ill. The combination is doubly disliked and often misunderstood. Many of the group are criminals only accidentally; what they have done to disturb the peace was merely incidental to their mental illness, but having been taken into court because they have destroyed something or assaulted someone they bear the unpleasant label throughout their illness. Others, however, have been hostile to society and have lived by violence or by conniving, prior to the time the mental illness developed. Among such patients there are likely to be a few who are desperately desirous of injuring someone

¹³⁶ Personal communication, Adolf Meyer, 1943

¹³⁷ Personal communication, Willis E. Ford, circa 1912.

¹³⁸ Adolf Meyer, "Report of the Pathological Institute for the Year Ending September 30, 1902." In Fourteenth Annual Report, New York (State) Commission in Lunacy (Albany, The Argus Company, 1903), pp 33-39, see also, "A Century of Psychiatric Research in America "

and who are therefore closely guarded and greatly restricted in their liberties. Unhappily the measures employed on this small group are too often chosen as the standard of care for all those who are mentally ill and have offended against the law, thereby greatly exaggerating the application of seclusion and general repression.

Since the social treatment of the mentally ill is an important part of their medical treatment, it seems desirable to separate those with a criminal background and criminal inclinations from those who have been pleasanter members of society, although this is not always done. In the 1850s there developed an effort to give these persons better care than they were getting in jail and prison. In New York State a law permitted the transfer from jails and prisons to the Utica State Hospital, but their numbers were so great that they would have crowded out the acute cases for whom the institution was built. In 1859 the first asylum for insane criminals was established at Auburn, in connection with a state prison. The next one was in Michigan, connected with the house of correction at Ionia. Both the New York and the Michigan institutions were after a time moved away from the prisons and given an independent existence. In several states the close relation between prison and hospital is still maintained, as in California, Indiana, Iowa, and Massachusetts. In more states there are some wards or a building for such patients in a state hospital, as in Colorado, Connecticut, Minnesota, and Missouri. The choice of arrangement depends principally on the number of such patients under care. Wherever ample special accommodations exist, additional patients are transferred into such an institution who prior to their mental illness were not criminals but who during the course of their mental illness have developed vengeful, aggressive trends. The transfer of such patients to the special hospital may save setting aside a whole ward of the larger hospital for close confinement. Some of these institutions and services for the insane criminals are very well run. Occupations, sport, and recreation are provided, and the hardships of close observation are mitigated so far as possible by fine grounds and buildings, and by good staff organization.

Unless ample provision is made for some special group, the large number of persons to be included in it may not be understood. In the South before the Civil War only an occasional Negro mental case was placed in a state institution. The first such admission was at Williamsburg in 1774.¹⁸⁹ It was commonly thought that few Negroes became mentally ill, and when

¹⁸⁹ Hurd, *op cit*, I, 371

many cases came to light after the War, it was believed that mental illness was the psychological price of their new freedom. The Southern States (including Maryland, Kentucky, and Missouri) have separate hospitals or separate wards for colored patients. The Veterans Administration maintains a hospital for colored veterans at Tuskegee, Alabama. In the states where special provision is offered, the hospitalization rate for Negroes is higher than for whites.

*Hospitalization Rate per 100,000 Population Aged 15 and Over*¹⁴⁰

	White	Negro
Alabama—1942	294 7	323 3
Maryland—1942	474 0	630 4
Virginia—1942	377 1	861 7
West Virginia—1941	296 0	442 2

Maintenance rates for Negro institutions are generally modest. As a rule a very considerable number of Negro patients work about the hospital. In the same region one is likely to find proportionately more graduate nurses in Negro than in white institutions.

Still another group for whom special arrangements have been advocated are the convalescents. After the colony plan¹⁴¹ had been established,¹⁴² an adaptation of that provision for convalescents was sometimes suggested—a place where the patient could spend the latter part of his hospital career and be better prepared in mind for undertaking life outside. Not much has been done in this line because so few patients are willing to spend any extra time away from home. However, in 1928 Mrs. L. Vernon Briggs financed such a colony at Hopkinton, Massachusetts.¹⁴³ Its capacity was eleven. A social worker and an occupational therapist from the Boston State Hospital were on the staff.

Colonies of the training schools for defectives are largely training posts for farmhands or houseworkers. The Rome (New York) State School made the broadest demonstration of their usefulness, and many other such institutions include them in their scheme.¹⁴⁴

With the expansion of state hospital systems and the large increase in numbers of patients with well-established mental disorders, there came

¹⁴⁰ Annual reports of Alabama, Maryland and Virginia, 1942. West Virginia figures obtained from the Bureau of the Census.

¹⁴¹ See p. 82.

¹⁴² Hurd, *op. cit.*, I, 161.

¹⁴³ *Bulletin*, Massachusetts Society for Mental Hygiene, January, 1929.

¹⁴⁴ Charles Bernstein, *Mental Hygiene*, VII (1923), 449.

recognition of the need of a somewhat different type of institution which should provide as good or better treatment. The treatment was not, however, to be prolonged, and therefore fewer beds would be needed. The new institution was to serve as a reception post and would therefore be used to encourage early admission of patients, teaching was to be one of its prominent functions, and hence it should be near a medical school whose students would profit by better instruction in psychiatry. Research was to be carried on by staff members with investigative minds, and sometimes by physicians with other interests who would come in for a period of full-time or part-time service to work on some psychiatric problem.

Frederick Peterson, L. Pierce Clark, and J. T. Eskridge presented well-reasoned papers to the Association, advocating in this country what was then called the "psychopathic hospital," with a large staff in relation to the number of patients and with facilities for earnest, thorough, and rapid study.¹⁴⁵ The first institution of this sort was planned for the University of Michigan, but the first to become effective was in Boston. The Boston Psychopathic Hospital, opened in 1912, has been a famous training post, known at home and abroad. There is a similar hospital in Ontario at Toronto. The attractiveness of the standards maintained in such institutions was eagerly seized upon by those who plan the affairs of the large mental hospitals; in a considerable number of them, some building that is newer and more comfortable than the average—particularly if it is used for the reception of patients—is labeled the "psychopathic building" of the state hospital to which it belongs.

Not to be separated from the psychopathic hospital except on grounds of administrative definition are the psychiatric services in general hospitals. These came into existence in several university hospitals because the faculty convinced the administration that psychiatry would be better taught if the university hospital had its own beds for patients. The first pavilion actually built under this program was opened in 1902 at the Albany Hospital.¹⁴⁶ This was quite independent of the state hospitals, and it differed from the later psychopathic wards in hospitals in that it was planned to keep a few patients for considerable periods of time. In other hospitals such wards were developed merely as humane provision for patients whose state of mind was under expert observation. The largest

¹⁴⁵ *Transactions of the Am Medico-Psychological Assn*, X (1903), 426-431; also, V (1898), 103-110, and VI (1899), 95-98.

¹⁴⁶ *Ibid*, XVII (1910), 142-151.

of these psychiatric services by all odds, and certainly one of the greatest as regards its humanitarian work, its teaching program, and its broad professional usefulness is that of Bellevue Hospital of New York City, which now has six hundred beds. Until after 1900 it was the only such service in the land.

Many other hospitals and hospital divisions have been developed.¹⁴⁷ Perhaps the most famous is the Phipps Clinic, a division of the Johns Hopkins Hospital in Baltimore, located in its own beautiful building near the children's building and not far from other services. The number of psychiatric services in general hospitals has come to be quite creditable, comparing favorably with the number on the continent of Europe. There are now nine well-organized and active psychopathic hospitals (separate and independent organizations) and more than one hundred ward services in general hospitals.

The movement to make suitable institutional provision for mental defectives ran a somewhat different course. It started in France and found leadership in Edouard Seguin. America was very fortunate in that this gentleman came here from France and continued to expound and work for this cause in Massachusetts, New York, and Pennsylvania. He was the first president of what is now the American Association on Mental Deficiency, founded in 1876 as the Association of Medical Officers of American Institutions for Idiotic and Feeble-minded Persons.¹⁴⁸ In Massachusetts, Samuel G. Howe, the great teacher of the blind, took the lead in this field, moving to develop a special school for teachable defectives. What is now the Walter E. Fernald School was opened in 1847, incorporated in 1848, and turned over to the state two years later. The early superintendents came to this school only by day; the first resident superintendent was the physician whose name the institution now bears. New York followed suit by opening an experimental school at Albany in 1851; it called to its direction Dr. Hervey B. Wilbur of Massachusetts.¹⁴⁹ In 1855 the school was moved to permanent quarters in Syracuse.

In the early mental hospitals, cases of untrainable mental defect were mixed in with the mentally ill, as they are to some extent today. The new movement recognized that providing custody alone was not giving to these persons all that science had made available, and logic demanded

¹⁴⁷ Hurd, *op. cit.*, II, 571-573.

¹⁴⁸ *Proceedings of the Association of Medical Officers of American Institutions for Idiotic and Feeble-minded Persons*, 1876, p. 5, also, Memorial to Dr. Seguin, 1880, pp. 14, 15.

¹⁴⁹ Hurd, *op. cit.*, III, 248.

that they have special institutions under the best auspices. In 1876 the Province of Ontario opened a school at Orillia which was specifically for low-grade patients. In the same year a woman member of the Board of State Charities of New York was shocked to find in county poorhouses imbecile and idiotic females who were mothers of illegitimate children.¹⁵⁰ Accordingly in 1878 a branch of Syracuse State School was developed in which feeble-minded women of childbearing age, too old for the educational program at the parent institution, might be humanely cared for; this became a separate institution at Newark in 1885. The same idea of separating the older people who were not so amenable to training governed the establishment of an institution at Rome in 1894, under the name of the State Custodial Asylum for Unteachable Idiots. These two styles of institutions—for the teachable and the unteachable—were copied elsewhere.

The public soon developed confidence in an institution that was doing beneficial work for its charges, whatever it was called. So people wanted their defective relatives in an active institution, without regard to its professed classification. Orillia, Newark, Rome, all became district institutions and received defectives of all grades from their districts, instead of accepting only persons who were to be kept in custody for many years. Generally speaking, the trend is to broaden the base of admission and to receive both high-grade and low-grade patients everywhere.

No one with the fervor and national influence of Dorothea Lynde Dix has arisen in this field, but in the period just before and after the first World War the National Committee for Mental Hygiene was in a position to give special assistance in the movement, and several institutions were established or enlarged as the result of the work of Drs. V. V. Anderson and Thomas H. Haines.

Still another group that needs special institutional accommodation is the convulsive disorders. Some of these are found in the mental hospitals, because in some instances they develop very definite and indeed very difficult mental conditions. Many more are cared for along with the mental defectives, because a large number of convulsive patients are notably defective in intellect. But others are clear-headed and smart.

The first institution specifically for epileptics was established at Gallipolis, Ohio, in 1890 and opened in 1893.¹⁵¹ The idea of the separation of

¹⁵⁰ *Proceedings of the Association of Medical Officers of American Institutions for Idiotic and Feeble-minded Persons*, 1876, pp. 98-99.

¹⁵¹ Hurd, *op cit*, III, 299.

buildings into many different groups was thoroughly carried out at the Craig Colony in western New York, to create for appreciative patients homes where they could be comfortable and have suitable occupation for life. Similar institutions have been developed at Woodstock, Ontario; Abilene, Texas; and Skillman, New Jersey. Numerous institutions care for both epileptic and mentally deficient groups: for instance, Sonoma, California; Mansfield Depot, Connecticut; Glenwood, Iowa; Lynchburg, Virginia; and Cambridge, Minnesota. Such institutions usually set aside several buildings for groups of convulsive patients and distribute those who are mentally deficient but without convulsive disorders in other wards or buildings. Such sharp segregation is not always practiced, and classification by temperament and interest seems sometimes more successful than classification by psychiatric diagnosis.

The excessive imbibition of alcoholic beverages has created human problems as far back as history goes. Heavy drinking was far from infrequent in the colonies and the temperance movement, though ultimately powerful, acquired force only gradually. Since many alcoholic persons are unable to control themselves, the necessity of institutional control is obvious; from the opening of the first mental hospital until the latest, patients have been accepted whose mental illness consisted of little more than the immediate effects of a debauch. In 1860 the Association listened to its first paper on inebriety.¹⁸²

Special hospitals for the inebriate were established in New York (1858), Ontario (1876), Massachusetts (1893), and later in other states.¹⁸³ Their founders started with high hopes and ended with disappointment. Most of the institutions have now been converted into mental hospitals. Some things were found out in these institutions that perhaps should have been known beforehand, but the human race proceeds by trial and error. Many alcoholics are disinclined to stay as long as their welfare seems to demand. Some alcoholics are competent to take advice, but others are highly incompetent; although intelligent and able to decide questions that are not related to their emotional problems, they have not the capacity ("strength of character") to take the drastic step into abstinence that is their only safety from further debauches. Some of the institutions for the inebriate were weak in having no long-time control over their patients. If the patient was committed for a period of several months, the institution usually lacked resources to keep him employed and in a reasonably cheerful state

¹⁸² H. M. Harlow, "Inebriety Considered as a Disease," *Am. J. Insanity*, XVII (1860), 45, 46.

¹⁸³ T. D. Crothers, "Hospitals for Inebriates," *N. Y. Med. J.*, XLIX (1911), 232.

of mind during that time. Many alcoholics entered the hospital without any desire for help but simply because their families drove them in. They continued to drink, either by getting liquor themselves or by having someone bring it in to them. One after another the institutions got a bad name. Probably if they had all had practical boards and a payroll so liberal that everyone from the superintendent down was well equipped for his job, better results would have been obtained. Of all these institutions, the one that survived latest was in Massachusetts; it moved from Foxborough to Norfolk in 1914 and was no longer needed in 1919. Such institutions did much good, and they contributed their share to the mighty "temperance movement." Out of one thousand cases received in five years at Binghamton, 60 per cent remained sober at least ten years. When Dr. Bucknill was in America in 1875, he went to the centennial celebration of the battle of Lexington.¹⁵⁴ In a throng of 150,000 people he saw nobody drunk and nobody rough.

The minutes of the Association bear ample testimony to the annoyance caused by nonpsychotic alcoholics in the mental hospitals, to the futility felt by numerous superintendents in dealing with them, and to the mixture of wrath, scorn, and helplessness engendered in the administrative head by the intrusion on his hospital population through court action of befuddled persons who within three or four days were on their feet and demanding their discharge. Over and over it is recited how these persons annoy the personnel, tease other patients, stir up dissatisfaction, bring in things that are unsafe to have in the institution, it is remarked how they demand what they consider to be their rights, how poorly they submit to order and discipline, and how frequently they run away. The threat of obtaining writs of habeas corpus has occasional mention. There are weary arguments for legislation that will keep such persons out of the institution, and laments at the time and effort wasted in trying to reform those who come in. Since in most of the country at the present time there are few or no institutions designed especially for inebriates, and since a great many inebriates are penniless, in some states they still go into the mental hospitals, being committed as mentally ill. When sober they obviously do not fall within the scope of the "insanity law" and must be discharged, lest they bring suit against the superintendent and mulct him of many dollars for unwarranted detention. A few states have a special form of inebriate commitment.¹⁵⁵

¹⁵⁴ Bucknill, *op cit*, p. 31

¹⁵⁵ E.g., California, Connecticut, Iowa. See Ballard and Fuller, *Mental Hygiene Laws in Brief* (New York, National Committee for Mental Hygiene, 1941)

In the early years of the institutions, nursing the mentally ill seems to have been on much the same level as other kinds of nursing in the community. In those days there were no schools of nursing, and when a physician wanted a nurse he picked some reasonably bright girl in the neighborhood and imparted to her some helpful techniques in addition to the lore of her own household.

In the hospitals attendants worked long hours—from early in the morning until patients were locked away for the night.¹⁵⁶ Only gradually were night attendants installed. The day employees had rooms in the ward and supposedly would hear an unusual commotion. In 1860 the most excellent attendants in the female department at Nashville were colored girls owned by that asylum.¹⁵⁷

Many institutions seem to have been well staffed. It is stated in an early issue of the *Journal* that 1 to 8 was the prevalent ratio of ward employees to patients.¹⁵⁸ This is the ratio which the American Psychiatric Association adopted as desirable in 1926, and which a considerable number of state institutions even now do not approach.¹⁵⁹ Figures obtained from the annual reports of various institutions to the U. S. Bureau of the Census are noted in Table II (p. 148).

In reports and elsewhere tribute was paid over and over to the fine spirit of many employees, but then—as now—there never seemed to be enough of the right persons to run all the wards. Too many who took these poorly paid positions came from homes that had not equipped them to handle the problems of the mental patient with both sympathy and intelligence. At the middle of the last century the hospitals for mental diseases were not alone in facing this difficulty. Other hospitals, too, employed ward attendants at low wages and too often gave dangerously inadequate attention to patients. One may recall in this connection what Dr. Oliver Wendell Holmes said about the perils of hospital care for the parturient woman.¹⁶⁰

Most patients have been cared for by members of their own sex. When Dr. Bemis of Worcester in 1867 said that he wanted some women on his men's wards, the editor of the *Journal* disparaged the idea.¹⁶¹ The opening

¹⁵⁶ *Am. J. Insanity*, I (1844), 7, 8.

¹⁵⁷ W. A. Cheatham, *Am. J. Insanity*, XVII (1860), 60.

¹⁵⁸ *Am. J. Insanity*, XI (1854), 133.

¹⁵⁹ *Am. J. Psychiatry*, LXXXII (1925), 300-306.

¹⁶⁰ O. W. Holmes, "The Contagiousness of Puerperal Fever," *New England Quarterly J. of Med. and Surg.*, April, 1843.

¹⁶¹ *Am. J. Insanity*, XXIV (1868), 429-431.

wedge was usually to have a married couple on duty in a ward for men. Indeed in the Boston Lunatic Asylum and a few other places married couples were in charge of women's wards, either during the day or at night. It was never an easy matter to have women serve in the men's wards until nurses' training had been instituted.

The ward personnel is very close to the lives of the patients and determines their confidence, their comfort, and often their very existence. In number, in training, in skill, and in spirit ward employees have varied greatly from one hospital to another. Some superintendents complained because attendants lacked vision and tact and required discipline for their conduct. Others paid tributes comparable to an observation of Dr. Stephen Smith of New York in 1886.¹⁰² He had been engaged in surgery, in military medicine, and in public health; then for some years he was state commissioner in lunacy. In a public address he commented:

When I began my official inspection of the institutions for the insane I entertained no friendly opinion towards their management. And especially did I regard the attendants as a class of men and women probably much below the average nurses in hospitals with which I am connected. I would be recreant to my sense of justice did I not in this place bear willing and emphatic testimony to the general good character of the attendants in the asylums. I have seen them in every capacity and tested them by every suitable method day and night, and I know of no class of employees who could have better sustained the scrutiny.

So far as we know the first course of lectures to attendants in this country was given in the New York Hospital by Dr. Valentine Seaman, in 1798.¹⁰³ Since the psychiatric service of that institution was under the same roof as the medical and surgical services, we cannot doubt that employees on the mental wards had the benefit of these lectures. Dr. Kirkbride gave lectures to employees in 1845.¹⁰⁴ The first training school for nurses in a general hospital in America was established in 1872, at the New England Women's and Children's Hospital.¹⁰⁵ This hospital had no psychiatric service.

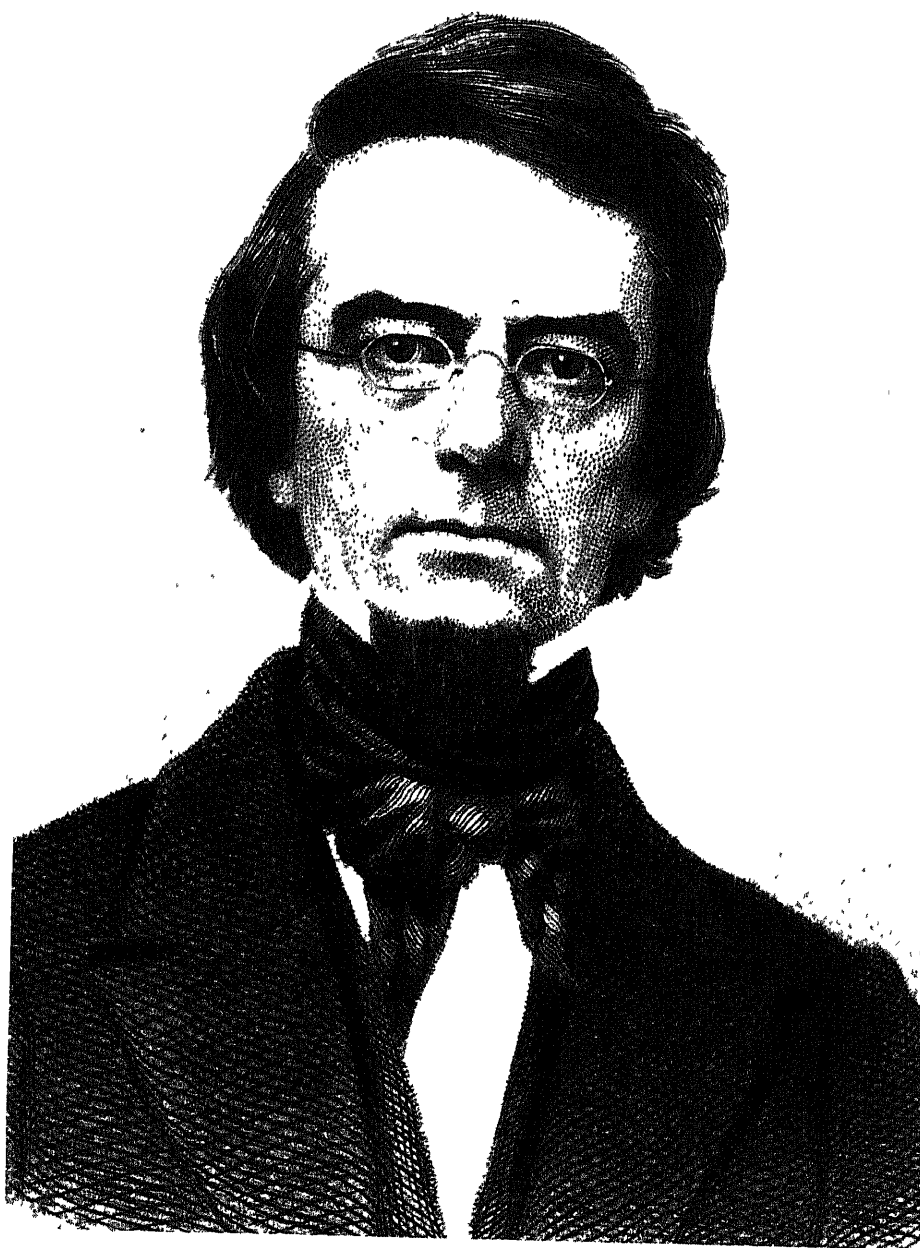
At the McLean Hospital only a few miles from Boston, Dr. Edward Cowles, seeking to improve the care of his patients, opened the first train-

¹⁰² "The Care of the Insane," *Am. J. Insanity*, XLIII (1887), 71, 72

¹⁰³ M. W. Raynor, "New York Hospital School of Nursing Commemorative Exercises," 1927, p. 84

¹⁰⁴ John B. Chapin, *Am. J. Insanity*, LV (1898), 122.

¹⁰⁵ Goodnow, *Nursing History in Brief* (Philadelphia, W. B. Saunders, 1943), p. 93



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ing school for nurses in a mental hospital in 1882.¹⁰⁶ Next came the school at the Buffalo State Hospital, the first class being graduated in 1888; and one at Kingston, Ontario, was opened that same year.¹⁰⁷ One institution after another followed suit until many, both private and public, had schools of nursing. Until nursing leaders grew so powerful that they could dictate rules, the indigenous standards of the many mental hospitals varied greatly. In some institutions every ward employee was required to take the nursing course, and if he or she was a valuable employee, failure to get a passing mark and a diploma was unlikely. In many places students drew attendants' wages during the years of instruction, had the same hours of duty, and very likely continued to work on the same ward to which they had been previously assigned. This seems like a crude educational procedure as compared with the elaboration of today's courses of nursing, but there were some fundamentally sound principles in it, and out of that kind of training came a large number of women and a not inconsiderable number of men who were faithful, reliable, and showed high ideals of service and a keen understanding of their patients. Many were adequately taught not only to care for ordinary illness but also to help in an operating room. Only ambitious persons, looking to future gains, were likely to take the course, because it brought no immediate financial benefits. To be sure, students got two or three hours off duty every week, but on the other hand they had to do their studying on their own time. Only after completion of the course, usually a two-year stretch, were wages likely to be increased. Presently the course was improved by affiliation with a general hospital, an arrangement started between McLean and the Massachusetts General Hospital in 1886.* A considerable number of the young nurses left the mental hospitals upon graduation to work elsewhere. Some superintendents complained of this and resorted to various schemes so that their students would be pretty well educated—but not so well that they would be likely to drift away.

Intelligent young persons, trying to learn and asking the older employee why things are done this way and that, make it easier for everyone to be alert, to understand the rationale of his methods, and to seek the best schemes. Accordingly the patients benefited. When nurses trained in the mental hospitals went out into general nursing, usually after taking an additional year of medical, surgical, and obstetrical training, they were

¹⁰⁶ Hurd, *op. cit.*, I, 295, 296

¹⁰⁷ *Ibid.*, I, 301

a gain to the world of nursing and made it easier for members of the community to obtain the proper kind of care for mental patients who did not need to enter an institution. Benefits are reciprocal. Miss Linda Richards, the first graduate nurse in the United States, organizer of several schools in general hospitals and in mental hospitals, remarked in 1915: "It stands to reason that the mentally sick should be at least as well cared for as the physically sick."¹⁰⁸ She adds that a course of study in a state hospital "often develops a pupil nurse in an astonishing manner. The average probationer does not possess a very large amount of patience or tact—two essential qualities in the making of a good nurse. In nursing the insane these qualities must be cultivated."

It is doubtful whether graduate nurses from outside schools were employed in any public mental hospital until they were brought in to set up training courses, and we do not know whether any private institution availed itself of that sort of care. Swept along by the current of medical progress, almost every mental hospital has accepted graduate nurses as the best qualified persons to direct the care of those patients who have concurrent or incidental physical ailments, but even in 1940 there was one three-thousand-bed institution without a single graduate nurse. The usual justification for having few or no graduate nurses involves the idea that more satisfactory results are obtained when the physicians pick their own helpers and teach them only what they need to know. On the negative side there is dislike of the independence and initiative shown by the graduate nurse, of her unwillingness to accept poor living conditions and hours of duty out of line with the custom of her neighborhood, and even of her unwillingness to accept old ways of looking after patients as being necessarily the best. The general judgment is that proper standards cannot be maintained without a considerable number of graduate nurses.

When it comes to what may properly be called psychiatric nursing—the application of the best nursing intelligence and training to the personal problems that have brought the patient to the institution, the problems of his conduct—there is again considerable variation. Standards in this regard are very high in many hospitals. In others both physicians and nurses seem content if only the physical ailments of selected patients in a few wards are given decent attention by a small number of graduate nurses with some attendant help; the nurses are not consistently informed

¹⁰⁸ Richards, *Reminiscences of America's First Trained Nurse* (Boston, Whitcomb & Barrows, 1915), pp. 108–110.

nor are they expected to inform themselves, by conference and study, about measures to improve the state of mind of their patients.

HISTORY'S notorious predilection for repeating itself is shown in this matter of training. The primary purpose of the schools was to equip young men and women to take better care of patients. In order to interest and retain keen young people it was necessary to give them courses so broad that they could turn their hands to general nursing if they wished. Then requirements for preliminary schooling were pushed upward by educational authorities, until many attendants are now quite unable to qualify. So the old problem recurs: How shall we have educated attendants? Graduates of three-year courses in general hospitals look askance at shorter courses in mental hospitals that lead to a diploma on which appears the word "nurse," and attendants are skeptical of two years of hard study unless it does bring the title "nurse," at least with some qualifying adjective. So patients now as in the 1880s sometimes get less than their physicians want them to have.

Short courses, usually compulsory, are given to attendants in many hospitals. They must be pitched to the pace of the slow-witted rather than to that of the quick-minded. These courses are indeed useful, but they bring only a negative reward—the attendant who does well in the course is less likely to be dismissed. The mental hospital world awaits another ingenious Cowles to solve the new form of the old problem.

In a general hospital one expects to find some nurse in charge of all nursing activities. This arrangement does not prevail in all mental hospitals, nor indeed in even a large majority of the best ones. The traditional organization of a mental institution was a superintendent, one or more assistant physicians, a male service whose personnel reported to the steward, and a female service whose personnel was responsible to the matron. As time went on, the other duties of the steward and the matron became so pressing that they were relieved of responsibility for ward activities. Persons who had displayed executive ability while in the ward service became supervisors, and the large institutions designated a head supervisor. As state departments of education and nursing examiners grew more particular about what should be called real education in nursing, it became essential to have a teaching section of the hospital under expert direction; perhaps a few wards were set aside as a service which the ranking nurse would control. She was usually given authority over the nurses in this section and over all the pupil nurses, but even then there

might be some interplay of responsibility between the head nurse and the head supervisor. The practical result has come to be that in many mental hospitals the person in all the nursing organization who is best trained and supposedly most competent, and certainly draws the largest salary, has the narrowest range of responsibility. The head supervisors, who very likely—though not necessarily—have been chosen from the graduate nurses, are responsible for the welfare of much larger numbers of patients, but their status is marked as inferior by the smaller salaries they draw; and yet they do not report to the head nurse but pursue independent courses.

No description of this customary organization of the hospital looks or sounds attractive; yet it has virtue as do all types of organization that are rooted in history, otherwise it would have been swept away. There are many hospitals in which this three-headed organization prevails. Indeed one hospital has six quite independent services headed each by a supervisor with no coördinating head nurse; each supervisor reports to a different physician, and the distribution of personnel from service to service, if not decided by the superintendent, is made by a clerical person in the central office.

Hours of duty a century ago stretched from before dawn to after dark, and then the attendant had to sleep in a room in the ward, subject to call at any hour. Later, "night watches" were appointed, and finally night attendants. Very gradually the employees were given quarters outside the patients' buildings. The three-shift work day was adopted at Kalamazoo, Michigan, in 1907, in Illinois in 1916, and in many states in the last two decades.¹⁶⁹

With regard to food, patients have received everything from what was excellent, according to standards of the day, down to meager—even inadequate, to say nothing of ill-balanced—rations. The corporate institutions, as might be expected, have always had the reputation of serving the best food. Many state hospitals have fed their patients well; the Veterans Hospitals do even better. In 1893 the New York State Commission in Lunacy authorized a study of state hospital rations by Dr. Austin Flint, professor of physiology in New York University.¹⁷⁰ His recommendations were reviewed by Professor Atwater of Wesleyan University, in 1898 and 1899,

¹⁶⁹ A. I. Noble, *Transactions of the Am. Medico-Psychological Assn.*, XIV (1907), 339-348; also, personal letter, R. H. Brandon, August, 1943.

¹⁷⁰ W. H. Kidder, "Food and Dietaries in Hospitals for the Insane," *Transactions of the Am. Medico-Psychological Assn.*, VII (1900), 291-301.

and the allowances then established have with occasional modifications greatly influenced feeding in American mental hospitals. Much good foodstuff goes into the kitchens of our mental hospitals, and a very considerable amount of attractive food emerges. It is also unhappily true that much food is rendered unattractive and even unpalatable when cooked by ignorant, ill-trained, and poorly supervised employees.

Hospital boards and superintendents who provide good food are naturally proud of it. In 1863 an experiment was tried for several months at Worcester; patients were fed the same diet as those in a state almshouse.¹⁷¹ They grew irritable and discontented, the excitable were more difficult to control, and the languid were more inert. When the usual diet was restored, there were early evidences of improvement. At present there is rising complaint of lack of important vitamins during the winter, particularly such as are found in fresh fruits and fresh vegetables. Dentists join with physicians in saying that though patients' weight may increase during the winter, susceptibility to infection increases, the mucous membrane of the mouth deteriorates, and skin lesions become frequent about the mouth and other body orifices.

There is no established scheme of administration for the preparation of food. In simpler days the steward told the matron what there was, and she had it cooked as she thought best. When kitchens grew big, a chef was appointed and the matron relinquished control. Later came the dietitian; Kings Park had one in 1900.¹⁷² In some places the dietitian has full charge of the preparation of food. In other hospitals she is an adjunct officer who sees to the preparation of special diets for the sick and perhaps supervises meals in the staff house. So humbly is she rated that in some New York State hospitals the superintendent may engage either a chef or a dietitian—but not both. In some places the dietitian is responsible for service also, thus raising countless questions as to who shall decide whether a particular patient is to be urged to eat or let alone. Too often a meager salary is expected to bring a mature and capable dietetic director. Better-balanced, better-prepared, and better-served food seemed to be on the way before the current war, but during the war standards have suffered.

When mental hospitals were small, the place where the patients should be fed constituted no particular problem. Ordinarily each ward had its

¹⁷¹ Memorial of Trustees of the Worcester Lunatic Hospital to the Honorable Senate and House of Representatives of Massachusetts. Quoted by E. Jarvis, *Am J Insanity*, XXII (1866), 257, 258.

¹⁷² *Transactions of the Am Medico-Psychological Assn*, VII (1900), 299.

own dining room, or a dining room might be placed between two wards. Small dining rooms close to the kitchen can be expected to supply the hottest food. As institutions grew larger and more wards were added, each ward still had its own dining room. But the time came when the system of small dining rooms was criticized, principally on the ground of expense. The time of employees was thought to be wasted, and too much food went into the garbage. A congregate dining room was opened in 1885 at the Athens State Hospital in Ohio.¹⁷³ This arrangement was copied elsewhere and the size of dining rooms increased; the Connecticut State Hospital at one time had seats for twelve hundred in one room. Supervision was easier, and those who liked the big rooms were sure that they saved money and gave service as good as or better than that in the small dining rooms. Needless to say there was a great variation in the way these dining rooms were operated. A few disagreeable patients could create confusion and turmoil that was hard for a visitor to disregard, though some might think that the patients quickly got used to it. Tribute is due to the late Arthur H. Harrington, whose operation of his one thousand-seat dining room at Howard, Rhode Island gave force to every sound argument for the congregate dining room.¹⁷⁴ Every detail of bringing food and removing dishes was carefully scheduled and suitably timed. Insulated carts transported food. Hot food was served on warm dishes. Gentle and attractive music was played by a small orchestra during the noon meal, which lasted a full hour, and although at some table back in the corner there were patients who liked to grumble and be slovenly, they were well controlled and made no discord in the general peace.

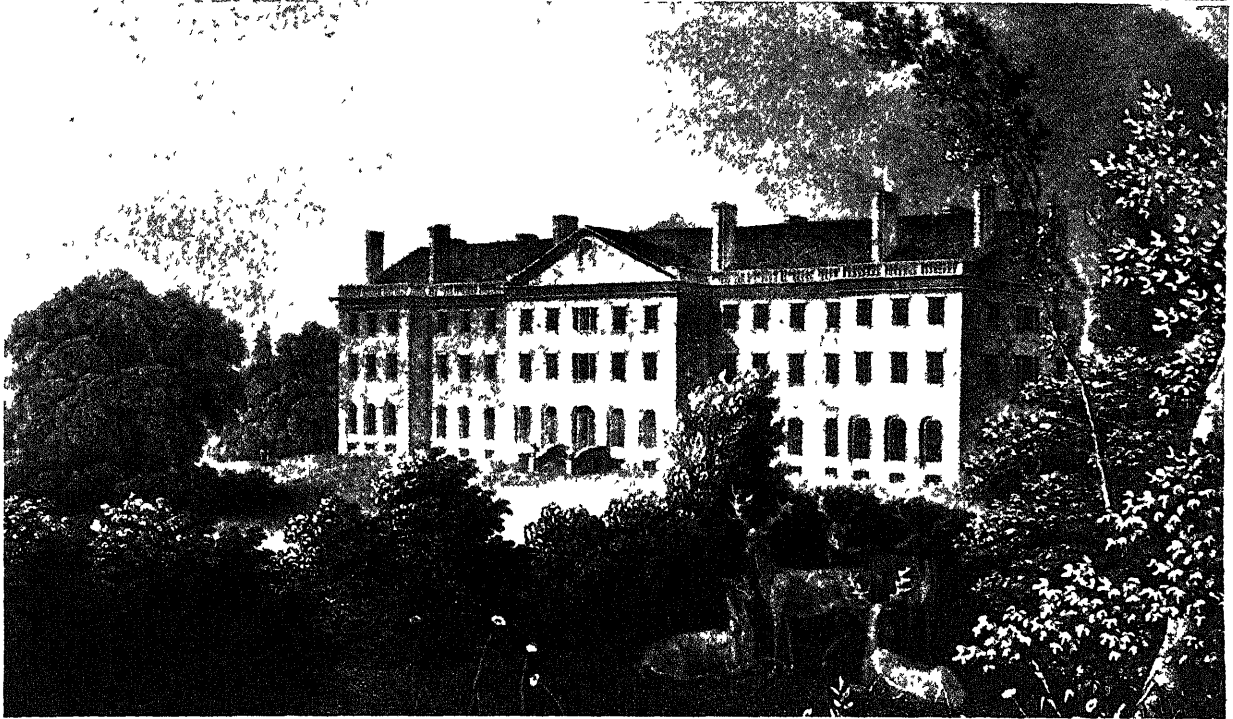
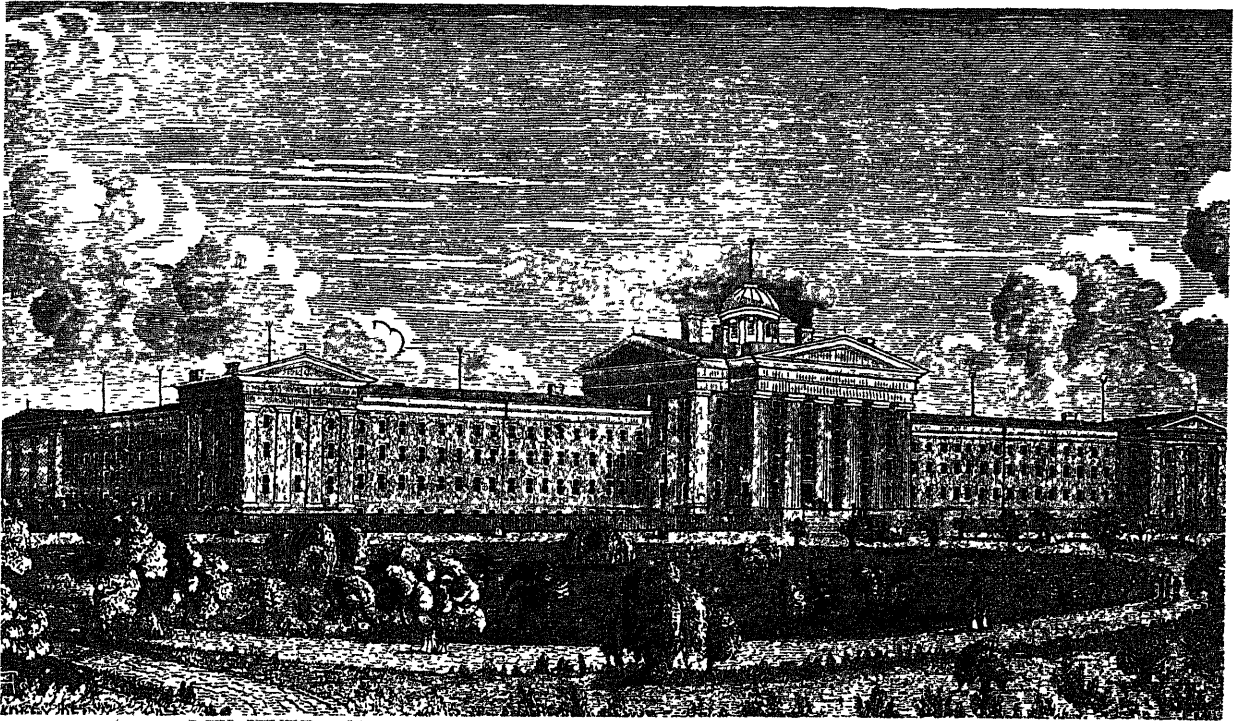
In spite of such examples, in many hospital dining rooms food of all sorts is spread on the plates before patients even come in, and the chance of getting a warm meal is slight. Such conditions led to dissatisfaction, and further experiments were carried on. The cafeteria came into commercial use, and in 1922 Dr. Herman M. Ostrander of Kalamazoo instituted one for four hundred workingmen patients.¹⁷⁵ The scheme found favor and is now widely used. It assures the service of hot food; nothing else is assured, and many of the most valuable possibilities are quite neglected in many hospitals. When a cafeteria is properly operated, the patients are not hurried past the counter but are given time to make a

¹⁷³ Thirteenth Annual Report of the Athens Asylum for the Insane, quoted in *Am. J. Insanity*, XLIII (1887), 503-505.

¹⁷⁴ *Am. J. Insanity*, LXX (1914), 487-496.

¹⁷⁵ Personal communication, 1923

NEW YORK STATE LUNATIC ASYLUM (UTICA)



BLOOMINGDALE ASYLUM (1806)

selection even though they are thoughtless and casual in so doing. Several alternative items are offered, and thus the powerful psychological factor of choice is brought to bear on the patient's approval of what he gets. Fluids can be served in such a way that they are not slopped over the tray by feeble or careless patients.

To one who sees the service of food throughout the country, it is all too evident that crude standards are winked at and in some places supported by hospital administrators, the justification being that they are as good as most of the patients have in their own homes. Probably so long as low per capita cost is the ideal, dining room service will continue to need improvement. On the other hand, there are many hospitals in which every dining room, including those for the most disturbed patients, is so conducted that a person who is not troubled by the vagaries of the patients has no qualms about joining them for a meal; the dishes are clean, the food attractive, the service competent, and the general atmosphere is agreeable.

The mental hospital has always been the place where advice was sought when a family was troubled by the mental state of one of its members. Time brought more calls for such service. The needs of those who might not have to go to a hospital but required office treatment and could not afford it privately led to the establishment of clinic service. For some years this work was done mostly by physicians on the staffs of mental hospitals.

In 1885 Dr. Chapin inaugurated an outpatient service twice a week in the downtown Pennsylvania Hospital.¹⁷⁶ In 1891 Dr. Fernald assigned a day a week to consultations at the Massachusetts State School, and by 1913 there were clinics for mental defectives in several other states.¹⁷⁷ In New York City, Cornell Medical School developed a mental clinic in 1904 which was carried on by Dr. Meyer and staff members of the State Pathological Institute.¹⁷⁸ The first regularly housed state hospital clinic was instituted by the St. Lawrence State Hospital in 1909.¹⁷⁹ The Illinois Society for Mental Hygiene started a clinic in 1909, and in 1913 the Boston Psychopathic Hospital and Phipps Clinic both developed outpatient work.¹⁸⁰ Progressive mental hospitals all over the country have such arrangements now, and a large number of the more experienced staff mem-

¹⁷⁶ Hurd, *op cit*, II, 415

¹⁷⁷ W. E. Fernald, *Mental Hygiene*, IV (1920), 848

¹⁷⁸ C. O. Cheney, *Am. J. Psychiatry*, LXXX (1923), 234.

¹⁷⁹ *Ibid.*, pp. 234-235.

¹⁸⁰ Unpublished manuscript, Chicago. Quoted by S. K. Jaffary, *The Mentally Ill and Public Provision for Their Care in Illinois* (Chicago, Univ. of Chicago Press, 1942), p. 118.

bers participate.¹⁸¹ In some hospitals one man gives most of his time to such work.

The primary purpose of a hospital, one may say, is to get patients in so that they may have the treatment they need. Soon afterward the hospital organization tries to get the patients out. There is no real contradiction between these two purposes, for the whole effort of the hospital between the time of entrance and the day of departure has been to bring about improvement.

When communities were smaller and there was little specialization in the practice of medicine, the same physician studied the condition of his patient before bringing him into the hospital, while he was there, and after he went back home. No complicated organization was necessary. But when specialties developed, and particularly when statistical methods were applied to the valuation of the many hospital procedures, it was found that something more was needed than some good advice to the person who came to take the convalescent away. Some collaborator of the physician was needed to follow the patient to his home, in many cases to precede him and prepare the way for him there, and report to the physician what elements in the home situation needed modification. After the patient had reached home this functionary would make one or several calls, assure himself that matters were going as they should, that proper compliance was given to the physician's orders, that unexpected complications had not arisen; if things were going badly the patient was helped to make a readjustment or was encouraged to come back to the hospital. Such procedures were classified under the term social work.

This description might apply to any kind of hospital; the need was particularly grave in the mental hospitals. Since most mental patients are ambulant and on discharge seem to be in reasonably good physical condition, it was essential that the social worker should know a good deal about motivation and interplay of personality among both the sick and the well. In short, she must be a psychiatrically trained person. Many of the early hospital social workers had been nurses.

"Aftercare" was the first term given to this type of work.¹⁸² It approached the problem in a very natural and very helpful way. Several hospitals formed aftercare committees. Members of hospital boards, representatives of social agencies, and other public-spirited persons were

¹⁸¹ *Directory of Psychiatric Clinics in the United States* (National Committee for Mental Hygiene, 1940)

¹⁸² Adolf Meyer *et al*, 18th annual report, New York State Commission in Lunacy, 1905-1906, pp 160-188

MCLEAN HOSPITAL



BUTLER HOSPITAL

given membership in such committees, and by a combination of volunteer and professional activities they made themselves very useful to a considerable number of hospital patients. It was obvious that such professional workers were already well occupied with the problems of their agencies, and that amateur social work, while very helpful if properly directed, was likely to be inadequate. The most interested and most competent amateur may be living in a place far away from the home of the patient who is in most need of help, and the amateur cannot be expected to go about the country following the problem patients into their homes. It was natural that the first professional social worker for a mental hospital should have been appointed in New York, where social work was well developed; this occurred in 1906 when a worker was appointed to serve the Manhattan and Central Islip State Hospitals.¹⁸³ During the first World War the famous School of Psychiatric Social Work was set up at Smith College.¹⁸⁴ Patients have been greatly aided through the development of psychiatric social work, and perhaps quite as much from the penetration of psychiatric knowledge and practice into the techniques of other social-work training. On the other hand, many of the most competent workers have been drained off from the hospitals for which they were originally trained to serve in a great variety of positions where their special psychiatric knowledge was found to supply a need often recognized, but previously hard to meet.

Social workers are now found on the staffs of most mental hospitals. Their training and experience before appointment vary tremendously. Their hours and activities are by no means similarly distributed in different institutions. The administrative idea of social work ranges from after-care with all its important implications down to mere history taking. Hospital physicians who have worked in both periods—that before the development of psychiatric social workers and after—bear happy testimony to the great advantages of the later period. The physician's influence on the life of his patient no longer ends when the patient goes through the hospital gate on his way home, and many patients are sent out who in former years would have been kept weeks, months, or even years longer in the institutions. When a vigorous program of social work is instituted, many more patients are given the benefit of earlier return to the community.

Observant people note that there are always many mentally ill persons

¹⁸³ Homer Folks *et al*, 18th annual report, New York State Commission in Lunacy, 1905-1906, p. 207.

¹⁸⁴ "Historical Sketch," *Hospital Social Service*, V (1922), 223

in the community—in other words that not all mentally ill persons need to be in hospitals. Some have been in hospitals and have attained a state in which they can be happier and can do better in a home, but for some reason cannot be expected to do well in their own home. Organizing a community to give patients the benefit of individual attention in the home has proceeded slowly on this continent, although five hundred years of European experiences were available.¹⁸⁵ It must be said, however, that until the later decades of the nineteenth century community care in Europe was crude and accompanied by exploitation, neglect, and even abuse in too many instances.

By the term “family care” we designate the placement, maintenance, and supervision in families other than their own of patients for whom the hospital is still responsible. Sometimes a family finances such an arrangement, but family care usually must be supported by the state maintaining the hospital. Until recent years the system has been little used in the United States or Canada; in some hospitals it seems even yet to be unheard of.

The Commonwealth of Massachusetts, leader in many good deeds, was the first state to set up family care, or the “boarding out” system.¹⁸⁶ Permissive legislation was obtained in 1885, and within a month two patients were placed. For years the number of patients in family care ran between three and four hundred. Aside from miscellaneous cases like one patient in Indiana and one in Minnesota, Massachusetts stood alone for several decades.

Family care was taken up seriously by New York in 1931, by one hospital in Pennsylvania in 1932, and by Ontario in 1934. A few years after its inception a situation arose in New York that demonstrated its acceptance by both physicians and patients. A reduction in appropriations forced diminution in the numbers in family care from about one thousand to less than seven hundred. Patients and their families were distressed and physicians were grieved at the necessity for the curtailment of this beneficent activity.¹⁸⁷

Recent statements indicate that the numbers in family care are rising in spite of the increasing cost of board and room. At the close of 1940, 902, or slightly less than one fifth of one per cent, of all patients on the

¹⁸⁵ H. M. Pollock, *Family Care of Mental Patients* (Utica, State Hospitals Press, 1936), pp. 115 ff.

¹⁸⁶ *Ibid.*, p. 34.

¹⁸⁷ “Are Family-care Colonies Practicable in New York State?” *Psychiatric Quarterly Supplement*, XIV (1940), 28–33.

books of state hospitals for mental disease were in family care.¹⁸⁸ With the exception of 209 in New York and 52 in Maryland, all of them were reported from New England—97 in Maine, 411 in Massachusetts, 132 in Rhode Island, and one in Connecticut. These figures should be considered as little more than indicative of the situation, for “family care” is still practiced in so few areas that its definition is not sufficiently understood throughout the country for reports thereon to be reliable. In the Province of Ontario, Canada, the term used is “boarding out”; here 457 insane patients were reported in family care at the end of 1941. In the last few years family care has been organized in California and Illinois. The former reported 454 patients in that status on June 30, 1942. Illinois perhaps includes some cases that usually are reckoned as on parole.

In the older countries one and sometimes two patients are placed in a family. They become members of the family, and a helpful, affectional relation grows up. In some states and in Ontario, usually under the pressure of circumstances but sometimes on a definite theory of action, larger numbers are placed in a family. Boardinghouse conditions are not all evil, and great numbers of adult citizens enjoy the life of boardinghouses. Similarly, many patients seem to do well under such circumstances. Therapeutic thought might be sharpened if a term were employed to differentiate those homes into which a patient is taken to be a member of the family from those in which several boarders are lodged and continue to make an impact on each other with their thoughts and feelings. Family care is genuine therapy. Patients whose mental illness seemed quite fixed have sometimes become more reasonable and more sociable when placed in a family and have ultimately been able to return to their own homes.

Great kindness can be shown the unfortunate without the use of money, but even the Good Samaritan put up some cash to accomplish his humane project for the “man that fell among thieves.”¹⁸⁹ The variation in maintenance rates in different hospitals is never fully accounted for, by difference of climate and its effect on consumption of fuel and on the weight of bedding and garments. More important differences are in the salaries and wages of employees.

¹⁸⁸ Bureau of the Census, *Patients in Mental Institutions, 1940*, p. 15. Institutional Statistics Branch, Dominion Bureau of Statistics, Tenth Annual Report of Mental Institutions, 1941, p. 13, also, “Statistical Report of the Department of Institutions of the State of California,” 1942.

¹⁸⁹ St. Luke, X, 35.

Some fugitive figures, illustrative of the contrasts, from earlier as well as recent periods are here noted.¹⁰⁰

<i>Hospital</i>	<i>Expenditures</i>				
	1870, 1871 ^a	1880, 1881 ^c	1922 ^d	1930 ^e	1942 ^f
Stockton State Hospital, California	\$166 20	\$150 86	\$257 92	\$257.53	\$305 82
Mt. Pleasant State Hospital, Iowa	208 00	210.60	260 63	255 23	236 28
Western State Hospital, Kentucky	212 16	167.28	169 37	158 06	(not reported)
Worcester State Hospital, Massachusetts	208 52	184 42	324 35	368 65	415 48 ^g
Willard State Hospital, New York	104.00	169 52	322.13	424 68	444 89
Manhattan State Hospital, New York	101 92 ^b	90 03 ^b	334 10	380 99	507 40
Dayton State Hospital, Ohio	254 80	198 04	256 64	263 82	193 40
Eastern State Hospital, Virginia	299 52	175 19	221 65	205 35	215 87
Central State Hospital, Virginia	266 24	158.08	167 49	141 22	168 16

When we come to later years, the Bureau of the Census gives interesting figures, not for individual hospitals but for whole states (see Table II, p. 148). Such a spread of appropriations is reflected in the sums spent for the several functions of any hospital. On higher payrolls one expects to find more and better-trained physicians. In 1940, as reported to the Bureau of the Census, 32 per cent of all physicians in state mental institutions were in the Middle Atlantic region, looking after 27 per cent of the patients.¹⁰¹ The number of patients per assistant physician (superintendents excluded) varied from 199 to 1 in New England to 386 to 1 in the East South Central Division. Eighty-four per cent of these institution physicians were working in the mental hospitals, 12 per cent in institutions for epileptics and defectives, and 4 per cent in other state mental

¹⁰⁰ ^a E. T. Wilkins, *op cit*, pp 219-220, 234-235.

^b New York City Asylum in earlier years

^c G. A. Tucker, *op cit*, pp 47-589 Data there given in pounds, shillings, pence.

^d Bureau of the Census, U. S. Department of Commerce, *Patients in Hospitals for Mental Disease*, 1923, pp. 252-257.

^e *Ibid.*, "Mental Patients in State Hospitals," 1929 and 1930, pp. 132-137.

^f State Reports for fiscal years ending in 1942, except Massachusetts

^g Report for fiscal year ending in 1940.

¹⁰¹ Bureau of the Census, *Patients in Mental Institutions*, 1940, pp 59, 96, 155, 157, 158

institutions. A study made between 1936 and 1939 showed that state hospital physicians were on the average younger than the average specialist and also younger than the average practitioner, many young physicians go to mental institutions with the idea of acquiring experience and some capital and then setting up private practice outside.¹⁹² Especially in the New England and Middle Atlantic districts, appointments to hospital positions were made predominantly when the physicians were under the age of thirty. In other regions more men were appointed at a more advanced age.

The last two decades of the history of the American Psychiatric Association have brought about expansion of mental hospitals in many directions. Much of this expansion has been well planned and effective; the reader will recall that the health of many patients within the institutions has been improved and that the health of many outside the institutions has been fostered or restored. Much of the expansion looks magnificent—to a degree of oppressiveness—but not well judged.

This has been the era of big things. Corporations that were large in 1900 became huge by 1944. The skyscraper has shot far aloft. The securities boom of the early twenties added enormously to peoples' ideas of their wealth and their prospect of comfort. Restraint on the size of institutions was thrown to the winds. Some able men uttered the dictum that it makes no difference how large an institution may be, that it is all just a question of organization. California and Illinois deliberately planned institutions for six thousand patients. New York already had some of these and planned one for ten thousand, but it found certain "economies" in connecting some buildings with others that would ultimately put another one or two thousand on the same limited ground space. In very many parts of the country, as more and more people needed to be accommodated, state authorities put up one building here and another there on the grounds of existing institutions without much regard to functional efficiency.

Some of this expansion was less economical than it seemed. Adding another building to a plant seemed to be economical because the same power plant, water system, laundry, and supervisory staff could apparently be stretched to take care of the additional hundred or five hundred patients, therefore it was thought that the appropriation need

¹⁹² Zubin and Scholz, "The Physician in State Institutions for the Mentally Ill and Mentally Handicapped," unpublished manuscript (New York, Mental Hospital Survey Committee, 1939).

not include expansion of those functions. But the story of one institution after another is that laundry facilities become inadequate, then the generator must be supplemented or replaced, then the heating plant is too small, the sewage disposal system gets overloaded, and finally even the water supply is threatened with breakdown. The administration of the huge hospital is not generally on such a level that the observer can prefer to have his own patient there rather than in a small institution. Superintendents often belittle their own importance by taking the position that it makes no difference whether they are responsible for one thousand or five thousand, that their assistants are perfectly capable of attending to the needs of the patients, that no superintendent needs to know his patients, and the like. This set of ideas is seized on now and then by those who have ulterior motives, and they inquire with some force why the superintendent should be a psychiatrist at all. An investigating commissioner in the State of New York has maintained that since these institutions are as big as a village, it is doubtful whether any physician ought to be at the head of them.

To indicate the trend in size, the accompanying tables have been prepared. Table III shows the number of state, veterans' and other public hospitals for the prolonged care of the mentally ill in the United States, with patients resident therein at censuses near the close of each of the last five decades, by size-groups of resident patients, these groups ranging from one of under 500 to one of 9,000-9,999; the same data are given in terms of per cent distribution. A pair of tables (IV-V) shows the extent to which institutions and patients resident therein come under the different types of control, including private.

So far as we know, the aim of those who have recommended increasing the size of institutions has always been economy in expenditure. There are psychiatrists who have defended the big institutions and said that it was proper policy to make a new institution as large as the architect proposed, but feeble indeed are the voices that have claimed that the treatment would be better in the huge rather than in the modest institution. It is true that by allocating only a fraction of a cent for some needed function one could make the cost of equipment seem very slight in a big institution, but over and over one finds that expansion in capacity is achieved at the expense of adequate numbers of trained personnel, whether the personnel be medical, nursing, special therapeutic, or dietetic. "Economy in overhead" is a specious phrase and has just enough

truth to be deceptive. But there are few advantages to patients from the multiplication of the low-paid jobs attracting persons of modest ability or those who are still young; the greater benefits to patients may be expected from high-priced brains. So far as medical service is concerned, it may be pointed out that in the New York State service each of the hospitals has one superintendent. Superintendents rise through the grades and there are few superintendencies; appointment comes when ripe experience has already carried the man past middle life. With regard to the next grade, a certain hospital of 2,400 patients has three positions for the second grade of physician; and the largest institution, of 9,000 patients, has only five medical positions of the same grade.¹⁸³ The average is 1 to 800 at one hospital, 1 to 1,800 at the other.

Except for St. Elizabeths in Washington, the Federal Government, perhaps because it was late in entering the field of mental hospitals, has withstood the urge for bigness very well. The highest capacity in any of the Veterans Administration Facilities is 2,220.¹⁸⁴ St. Elizabeths, however, has now passed the 7,000-bed mark.

Sanitary conditions are likely to be well maintained where therapy is active, though not always. Some states stress sanitary inspection, others should have a division of sanitary inspection, but legislative and administrative authorities do not always realize its importance and think that such work can be done in leisure moments by another official, perhaps by one from the state department of health. Departments of health invariably assert that they have scarcely enough inspectors to protect the public against dirt and recklessness in restaurants, road camps, and factories. There appears to be no state service in which the important function of inspection is sufficiently respected to be given a thoroughly adequate staff, but some states do much better than others. Only one state makes its inspectional service primarily a means of determining the fitness for retention of every patient admitted. Perhaps this precaution is superfluous, but it has certainly robbed many ignorant critics of their complaints about "railroading" and improper detention.

The second World War has brought a partial redistribution of the responsibility for care of the mentally ill, since a very large part of those who develop mental illnesses while serving their country are entitled to Federal care. At the same time came an improvement in the economic

¹⁸³ *Handbook of the Department of Mental Hygiene* (New York, 1942), pp. 17, 41

¹⁸⁴ U. S. Veterans Bureau communication, June 19, 1943

situation of many families due to the war boom in industries, and in some places the admissions to state hospitals fell off for at least a time. Civil hospitals, however, are not relieved for any long period of the increasing number of old-age patients with psychosis.

In our field the most obvious effects of the war have been due to the loss of personnel to industry and the military forces. At the time these pages are being written there is a lamentable decline in standards of care. For a while the older employees whose lives had become entwined in the activities of the institutions were able to carry on their work without much loss of efficiency, but as the total number of employees declined and the relative number of inexperienced and less sagacious people took the place of the more intelligent, unfortunate conditions arose. A vast amount of ingenuity has been exercised in filling as many vacancies as possible, but substandard practices have to be accepted. It will doubtless take some time to uproot them when employment conditions are more normal.

Progress in the mental hospitals suffers from lack of competition. By contrast, the general hospitals are so numerous that standards and results are always under comparison. Vast amounts of private money go into their maintenance. Trustees, ladies' auxiliaries, chambers of commerce, and the newspapers all help to keep any administrator from falling into a rut. For general hospitals a thousand beds constitute a large institution. The situation in public mental hospitals is very different. Too often there is lack of continuity in the appropriating bodies, and in many states the hospital has no local board to bring the needs of the patients to the attention of those who hold the purse strings. Sometimes a superintendent works miracles, but miracles may not be enough. On the Eastern seaboard the little group of corporate institutions comes nearest to furnishing what might be called competition.

On many accounts it is fortunate that the Federal Government has entered this field. Appropriations to its hospitals are much more liberal than those of most of the states. Some of the additional expense is eaten up by extra bookkeeping and other paper work that needs a larger staff and more time, but most of the money spent goes for better equipment, better clothing, better food, better service, a better paid ward personnel, a better program of work and play. In time such standards must impress themselves on the people of any community. People come to recognize the injustice of meager and inadequate care of a veteran's wife who be-

comes mentally ill, when they compare it with the excellent care that the veteran himself may have if he needs it. In some neighborhoods the medical staffs of state and Federal institutions have banded together in medical societies for the comparison of experience and the discussion of scientific matters. Interchange of thought among nurses and other types of personnel has been frequent. The wide disparity in maintenance cost has been a barrier to the adoption of procedures from one type of hospital to the other, but nevertheless some of the improved procedures have been thus adopted. A great number of patients have spent some time in a state hospital before being accepted at a veterans' hospital, and the critical opinions expressed by them have strengthened the hands of those who are working for more adequate support, better procedure, and better standards in the state hospitals.

TABLE II
SUMMARY DATA, STATE HOSPITALS FOR MENTAL DISEASE
BY GEOGRAPHIC DIVISIONS AND STATES: 1940

Division and State	Hospitaliza- tion rate per 100,000 pop- ulation aged 15 and over ^a	First admis- sion rate per 100,000 pop- ulation aged 15 and over ^b	Number of patients per assistant physician ^c	Number of patients per ward employee ^d	Per capita expenditures for mainte- nance ^e
UNITED STATES	409.6	80.5	240.6	9.3	\$300.63
NEW ENGLAND	591.2	101.1	200.1	7.4	387.87
Maine	412.2	56.1	263.7	9.7	304.90
New Hampshire	597.7	141.5	202.4	7.2	382.92
Vermont	398.6	83.6	261.0	9.5	287.05
Massachusetts	677.4	114.7	201.2	7.0	424.93
Rhode Island	498.6	93.6	157.7	9.0	303.19
Connecticut	532.6	83.0	193.2	7.0	355.71
MIDDLE ATLANTIC	499.5	88.1	188.5	7.3	377.36
New York	689.7	123.5	188.4	6.7	398.11
New Jersey	323.9	67.9	159.9	8.0	395.01
Pennsylvania	305.2	46.5	207.0	9.6	299.60
EAST NORTH CENTRAL	377.6	79.5	262.4	10.3	296.92
Ohio	365.1	68.3	325.7	14.5	203.46
Indiana	334.7	63.1	361.9	11.6	201.56
Illinois	501.6	116.3	245.2	10.9	272.43
Michigan	407.3	63.3	226.0	7.1	481.62
Wisconsin	77.5	53.4	153.8	5.9	501.42
WEST NORTH CENTRAL	376.6	71.8	281.0	11.1	231.17
Minnesota	482.8	82.4	437.9	12.0	212.77
Iowa	337.2	58.5	269.5	10.8	221.31
Missouri	312.3	76.0	239.2	10.4	266.93
North Dakota	423.8	78.4	319.8	11.6	237.13
South Dakota	341.0	51.0	200.6	12.8	240.66
Nebraska	428.6	74.4	186.2	8.5	246.83
Kansas	364.1	68.4	327.8	14.5	198.94

^a Population enumerated of April 1, 1940 U. S. Bureau of the Census, *Patients in Mental Institutions, 1940*, Table 9, p. 17.

^b Population enumerated as of April 1, 1940 *Ibid.*, Table 10, p. 18.

^c Superintendents not included. *Ibid.*, Table 34, p. 59 (columns headed "Assistant physicians" and "Medical internes") and Table 37, p. 63 (column headed "Average daily resident patient population").

^d *Ibid.*, Table 34, p. 60 (columns headed "Graduate nurses" and "Other nurses and attendants") and Table 37, p. 63 (column headed "Average daily resident patient population").

^e *Ibid.*, Table 37, p. 63.

TABLE II (continued)

SUMMARY DATA, STATE HOSPITALS FOR MENTAL DISEASE
BY GEOGRAPHIC DIVISIONS AND STATES: 1940

Division and State	Hospitaliza- tion rate per 100,000 pop- ulation aged 15 and over ^a	First admis- sion rate per 100,000 pop- ulation aged 15 and over ^b	Number of patients per assistant physician ^c	Number of patients per ward employee ^d	Per capita expenditures for mainte- nance ^e
SOUTH ATLANTIC	405.8	81.3	244.0	10.4	\$268.77
Delaware	591.3	117.5	99.1	8.7	379.95
Maryland	550.6	67.0	198.6	10.8	233.43
District of Columbia	1,137.4	189.2	123.7	5.3	666.21
Virginia	484.4	131.2	381.2	12.6	188.50
West Virginia	299.7	71.2	245.1	17.6	177.70
North Carolina	305.3	71.3	402.7	14.9	157.86
South Carolina	359.7	83.0	235.8	10.6	263.58
Georgia	338.5	51.2	324.2	11.7	204.08
Florida	331.0	52.1	384.3	10.5	265.10
EAST SOUTH CENTRAL^f	"	"	374.0	13.7	171.87
Kentucky	321.5	80.2	454.3	15.1	147.31
Tennessee	268.2	61.2	276.7	15.2	158.00
Alabama	302.1	78.6	514.8	11.5	200.31
Mississippi	55.9	16.5	192.5	12.8	265.12
WEST SOUTH CENTRAL	340.4	67.1	326.4	13.7	201.70
Arkansas	326.0	95.7	339.0	14.4	193.72
Louisiana	393.0	71.9	324.5	13.6	180.25
Oklahoma	430.7	93.0	439.9	14.5	198.99
Texas	293.3	47.7	285.0	13.2	216.13
MOUNTAIN^f	"	"	290.0	8.6	261.57
Montana					
Idaho	265.3	78.2	198.4	12.0	258.45
Wyoming	333.1	70.1	298.0	13.2	219.86
Colorado	470.6	39.5	327.9	7.6	276.11
New Mexico	262.5	58.3	882.0	7.2	242.70
Arizona					
Utah	282.0	76.1	175.5	9.5	258.16
Nevada	408.7	94.8	371.0	12.4	237.22
PACIFIC	433.1	102.3	319.8	10.8	267.17
Washington	473.9	93.6	238.1	10.5	238.35
Oregon	489.4	109.3	331.2	14.7	179.14
California	414.3	103.3	351.6	10.4	290.58

^f One Mississippi State Hospital and the State Hospital of Montana and of Arizona not reported.^e Rate not computed.

TABLE III

PUBLIC INSTITUTIONS FOR THE PROLONGED CARE OF THE MENTALLY ILL IN THE UNITED STATES WITH PATIENTS RESIDENT THEREIN AT CENSUSES NEAR THE CLOSE OF EACH OF THE LAST FIVE DECADES, BY SIZE-GROUP OF RESIDENT PATIENTS AND TYPE OF CONTROL^a

Type of Control	Total		Under 500		500-999		1,000-1,999		2,000-2,999		3,000-3,999		4,000-4,999		5,000-5,999		6,000-6,999		7,000-7,999		8,000-8,999		9,000-9,999	
	Institu- tions	Resident patients	Institu- tions	Resident patients	Institu- tions	Resident patients	Institu- tions	Resident patients	Institu- tions	Resident patients	Institu- tions	Resident patients	Institu- tions	Resident patients	Institu- tions	Resident patients	Institu- tions	Resident patients	Institu- tions	Resident patients	Institu- tions	Resident patients	Institu- tions	Resident patients
Total	220	142,969	111	17,847	52	38,191	47	61,832	9	21,580	1	3,519	—	—	—	—	—	—	—	—	—	—	—	—
State	131	126,137	31	9,368	46	34,418	44	57,252	9	21,580	1	3,519	—	—	—	—	—	—	—	—	—	—	—	—
Veterans'	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Other public	89	16,832	80	8,479	6	3,773	3	4,580	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	242	178,521	112	14,649	55	39,372	60	83,235	11	26,672	3	10,193	1	4,400	—	—	—	—	—	—	—	—	—	—
State	136	157,315	18	5,446	47	34,278	58	80,674	9	22,324	3	10,193	1	4,400	—	—	—	—	—	—	—	—	—	—
Veterans'	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Other public	106	21,206	94	9,203	8	5,094	2	2,561	2	4,348	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Total ^b	310	228,006	18	3,952	38	28,384	74	108,349	22	52,449	5	18,523	1	4,536	1	5,369	1	6,444	—	—	—	—	—	—
State	160	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Veterans' ^b	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Other public ^b	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Total ^b	255	365,517	12	3,735	19	16,237	78	118,936	35	85,733	15	51,677	7	29,763	1	5,688	1	6,287	—	—	—	—	—	—
State	168	318,056	1	433	11	7,641	4	4,835	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Veterans'	16	12,909	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Other public ^b	71	34,552	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	292	476,848	92	18,053	22	17,094	78	115,671	62	151,710	16	54,881	12	53,268	4	22,109	3	19,660	2	15,225	—	—	1	9,177
State	181	419,374	14	4,745	13	10,827	58	89,631	60	147,038	14	47,674	12	53,268	4	22,109	3	19,660	2	15,225	—	—	1	9,177
Veterans'	26	29,018	3	1,267	5	3,432	17	22,121	1	2,198	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Other public	85	28,456	75	12,041	4	2,835	3	3,899	1	2,474	2	7,207	—	—	—	—	—	—	—	—	—	—	—	—

DISTRIBUTION IN PERCENTAGE

TABLE IV
INSTITUTIONS FOR THE PROLONGED CARE OF THE MENTALLY ILL IN THE UNITED STATES:
NUMBER AND PER CENT DISTRIBUTION BY TYPE OF CONTROL^a

Date of Census	Total		State		Veterans'		Other Public		Private	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
December 31, 1903	325	100 0	131	40 3			89	27 4	105	32 3
January 1, 1910	361	100 0	136	37 7			106	29 3	119	33 0
January 1, 1923 ^b	523	100 0	160	30 6	Date not available				213	40 7
January 1, 1933	483	100 0	168	34 8	16	3 3	71	14 7	228	47 2
December 31, 1941	475	100 0	181	38 1	26	5 5	85	17 9	183	38 5

^a Bureau of the Census, U. S. Department of Commerce *Insane and Feeble-minded in Hospitals and Institutions, 1904, Insane and Feeble-minded in Institutions, 1910, Patients in Hospitals for Mental Disease, 1923, Patients in Hospitals for Mental Disease, 1933, Communications concerned with forthcoming publication, Patients in Mental Institutions, 1941*

The data as reported here vary slightly from those published by the Census for the same years. This is due to an endeavor to interpret certain data in the same fashion for all five years, and to eliminate figures for those institutions not providing prolonged care.

^b For blank columns, data not available

TABLE V
PATIENTS RESIDENT IN INSTITUTIONS FOR THE PROLONGED CARE OF THE MENTALLY ILL
IN THE UNITED STATES: NUMBER AND PER CENT DISTRIBUTION BY TYPE OF CONTROL^a

Date of Census	Total		State		Veterans'		Other Public		Private	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
December 31, 1903	150,024	100 0	126,137	84 1			16,832	11 2	7,055	4 7
January 1, 1910	187,114	100 0	157,315	84 1			21,206	11 3	8,593	4 6
January 1, 1923 ^b	267,444	100 0	228,006	85 3	Data not available					
January 1, 1933	376,748	100 0	318,056	84 4	12,909	3 4	34,552	9 2	11,231	3 0
December 31, 1941	488,094	100 0	419,374	85 9	29,018	6 0	28,456	5 8	11,246	2 3

^a Bureau of the Census, U. S. Department of Commerce *Insane and Feeble-minded in Hospitals and Institutions, 1904, Insane and Feeble-minded in Institutions, 1910; Patients in Hospitals for Mental Disease, 1923, Patients in Hospitals for Mental Disease, 1933, Communications concerned with forthcoming publication, Patients in Mental Institutions, 1941*

The data as reported here vary slightly from those published by the Census for the same years. This is due to an endeavor to interpret certain data in the same fashion for all five years, and to eliminate figures for those institutions not providing prolonged care.

^b For blank columns, data not available

EXISTING INSTITUTIONS FOR THE MENTALLY ILL IN THE UNITED STATES
WITH DATE OF OPENING AND PRESENT CONTROL

<i>State Mental Institutions</i>	<i>Date of Opening</i>
Eastern State Hospital, Williamsburg, Virginia	1773
Spring Grove State Hospital, Catonsville, Maryland ^a	1798
Eastern State Hospital, Lexington, Kentucky	1824
Manhattan State Hospital, New York City, New York ^b	1825
Western State Hospital, Staunton, Virginia	1828
South Carolina State Hospital, Columbia, South Carolina	1828
Worcester State Hospital, Worcester, Massachusetts	1833
Columbus State Hospital, Columbus, Ohio	1838
Boston State Hospital, Boston, Massachusetts ^c	1839
Brooklyn State Hospital, Brooklyn, New York ^d	1839
Central State Hospital, Nashville, Tennessee	1840
Augusta State Hospital, Augusta, Maine	1840

* A question mark preceding the date indicates that no one of two or more reported dates of opening can be accepted as authoritative. The one presented appears to be most nearly correct.

^a This institution, though State owned, was controlled and operated by Baltimore City from 1798 to 1808 under the name of the Public Hospital of Baltimore, in 1808 it was leased by the City to a private individual for use as a general and mental hospital, in 1834, the State of Maryland reasserted its control, called the institution the Maryland Hospital and restricted it to the insane. Henry M. Hurd, ed., *The Institutional Care of the Insane*, 1916, II, 518.

^b From 1825 to 1839 patients were domiciled in the basement and first story of the building which had recently been erected as a general hospital in connection with the almshouse, then situated on the grounds of the present Bellevue Hospital. On June 10, 1839 patients were removed from the almshouse and hospital at Bellevue to the new asylum on Blackwell's Island, the first county asylum to be erected in the State. Through the years colonies were established on Ward's Island, Randall's Island, Hart's Island and Central Islip, also, and the institution was then known as the New York City Asylum. Blackwell's Island and Hart's Island were abandoned in 1894 and 1896, respectively. In 1896 New York State assumed control and the institution was renamed the Manhattan State Hospital. In 1900 the institution was separated into Manhattan State Hospital, East and West, and in 1905 again consolidated into one institution. *Ibid.*, III, 201.

^c Originally established and opened as a City institution, the State of Massachusetts assumed control in 1908. *Ibid.*, II, 645.

^d In 1839 Kings County opened its first asylum exclusively for the mentally ill (later called the Flatbush Branch). In 1885 a branch at St. Johnland opened (called Kings Park in 1891). In 1895 the Flatbush and Kings Park branches became the Long Island State Hospital, Kings Park was transferred to the State and the Flatbush division was leased to the State. In 1900 each department became a separate institution—the Flatbush division, now called the Brooklyn State Hospital, and the Kings Park division, now known as the Kings Park State Hospital. *Ibid.*, III, 214.

New Hampshire State Hospital, Concord, New Hampshire	1842
Milledgeville State Hospital, Milledgeville, Georgia	1842
Utica State Hospital, Utica, New York	1843
Central State Hospital, Indianapolis, Indiana	1848
New Jersey State Hospital, Trenton, New Jersey	1848
East Louisiana State Hospital, Jackson, Louisiana	1848
Philadelphia State Hospital, Philadelphia, Pennsylvania*	1849
Harrisburg State Hospital, Harrisburg, Pennsylvania	1851
State Hospital No 1, Fulton, Missouri	1851
Jacksonville State Hospital, Jacksonville, Illinois	1851
Stockton State Hospital, Stockton, California ²	1851
Woodville State Hospital, Woodville, Pennsylvania ²	(?)1853
Taunton State Hospital, Taunton, Massachusetts	1854
Western State Hospital, Hopkinsville, Kentucky	1854
Cleveland State Hospital, Cleveland, Ohio	1855
Dayton State Hospital, Dayton, Ohio	1855
St. Elizabeths Hospital, Washington, D. C. ³	1855
Mississippi State Hospital, Whitfield, Mississippi	1856
State Hospital, Raleigh, North Carolina	1856
Northampton State Hospital, Northampton, Massachusetts	1858
Kalamazoo State Hospital, Kalamazoo, Michigan	1859
Matteawan State Hospital, Beacon, New York ⁴	1859
Weston State Hospital, Weston, West Virginia	1859
Longview State Hospital, Cincinnati, Ohio ⁵	1860
Bryce Hospital, Tuscaloosa, Alabama	1860
Mendota State Hospital, Mendota, Wisconsin	1860
Mount Pleasant State Hospital, Mount Pleasant, Iowa	1861

* The insane were cared for in the Philadelphia Almshouse (Blockley) for many years prior to 1849 when, for the first time, a physician was appointed to take charge of the insane, in 1859 the insane department was separated from the general hospital. In 1911 the Byberry City Farms were acquired for the additional accommodation of the insane. On October 21, 1938 the Philadelphia Hospital for Mental Diseases (as it was called in later years) was transferred by the city to the State of Pennsylvania. Personal correspondence with the Bureau of Mental Health, Pennsylvania.

² Authorized as a State institution in 1853. Statistical Report of the Department of Institutions, California, 1942, p. 7.

³ Originally the Allegheny County Hospital. The State of Pennsylvania assumed control May 1, 1941. Personal correspondence with the Bureau of Mental Health, Pennsylvania.

⁴ Although under the control of the United States Public Health Service, this institution is commonly classed with the state hospitals.

⁵ Originally established at the Auburn Prison, the present building was opened at Beacon in 1892 and called the Matteawan State Hospital. Hurd, *op cit*, III, 241.

⁶ The Longview Asylum was built and opened by Hamilton County in 1860 for its residents (in 1857 a subsidy was authorized by the State of Ohio). *Ibid*, III, 336. In 1926 the State agreed to purchase the hospital from Hamilton County and in 1927 the first payment was made. *Longview, an Ohio State Hospital in Cincinnati for the Mentally Ill*, 1938.

Austin State Hospital, Austin, Texas	1861
Rochester State Hospital, Rochester, New York*	1863
Clarks Summit State Hospital, Clarks Summit, Pennsylvania ¹	(?)1863
Osawatomie State Hospital, Osawatomie, Kansas	1866
St. Peter State Hospital, St. Peter, Minnesota	1866
Mental Wards, Tewksbury State Hospital and Infirmary, Tewksbury, Massachusetts	1866
Connecticut State Hospital, Middletown, Connecticut	1868
Willard State Hospital, Willard, New York	1869
Central State Hospital, Petersburg, Virginia	1869
Chicago State Hospital, Chicago, Illinois ^m	1870
State Hospital for Mental Diseases, Howard, Rhode Island	1870
Hudson River State Hospital, Poughkeepsie, New York	1871
Western State Hospital, Fort Steilacoom, Washington	1871
Lincoln State Hospital, Lincoln, Nebraska	1871
Danville State Hospital, Danville, Pennsylvania	1872
Elgin State Hospital, Elgin, Illinois	1872
Independence State Hospital, Independence, Iowa	1873
Anna State Hospital, Anna, Illinois	1873
Winnebago State Hospital, Winnebago, Wisconsin	1873
Central State Hospital, Lakeland, Kentucky	1873
Athens State Hospital, Athens, Ohio	1874
Middletown State Homeopathic Hospital, Middletown, New York	1874
State Hospital No. 2, St. Joseph, Missouri	1874
Napa State Hospital, Imola, California	1875
New Jersey State Hospital, Greystone Park, New Jersey	1876
Florida State Hospital, Chattahoochee, Florida	1877
Grafton State Hospital, North Grafton, Massachusetts	1877
Montana State Hospital, Warm Springs, Montana ⁿ	1877
Danvers State Hospital, Hathorne, Massachusetts	1878
Pontiac State Hospital, Pontiac, Michigan	1878
Topeka State Hospital, Topeka, Kansas	1879
Kankakee State Hospital, Kankakee, Illinois	1879
Rochester State Hospital, Rochester, Minnesota	1879
Yankton State Hospital, Yankton, South Dakota	1879

* This institution was under county control until 1891 when it was transferred to the State of New York. Hurd, *op cit*, III, 199

¹ Originally a county institution called the "Hillside Home and Hospital for Mental Diseases." Although the hospital now is wholly supported by the State, the matter of final transfer of control was still under discussion in July, 1943. Personal correspondence with the Bureau of Mental Health, Pennsylvania

^m Although established originally by Cook County, the State of Illinois assumed control in 1912. Hurd, *op cit*, II, 280

ⁿ From 1877 to 1912 the institution was privately owned and state patients were subsidized by the State, in 1912 the State of Montana assumed ownership. *Ibid*, III, 4.

Buffalo State Hospital, Buffalo, New York	1880
Warren State Hospital, Warren, Pennsylvania	1880
Norristown State Hospital, Norristown, Pennsylvania	1880
State Hospital, Goldsboro, North Carolina	1880
Binghamton State Hospital, Binghamton, New York	1881
Nevada State Hospital for Mental Diseases, Reno, Nevada	1882
State Hospital, Morganton, North Carolina	1883
Colorado State Hospital, Pueblo, Colorado	1883
Oregon State Hospital, Salem, Oregon	1883
State Hospital, Little Rock, Arkansas	1883
Utah State Hospital, Provo, Utah	1885
Traverse City State Hospital, Traverse City, Michigan	1885
East Mississippi State Hospital, Meridian, Mississippi	1885
Ionia State Hospital, Ionia, Michigan •	1885
North Dakota State Hospital for Insane, Jamestown, North Dakota	1885
Terrell State Hospital, Terrell, Texas	1885
Toledo State Hospital, Toledo, Ohio	1885
Kings Park State Hospital, Kings Park, New York°	1885
Eastern State Hospital, Knoxville, Tennessee	1886
State Hospital, South, Blackfoot, Idaho	1886
Westboro State Hospital, Westboro, Massachusetts	1886
Southwestern State Hospital, Marion, Virginia	1887
State Hospital No. 3, Nevada, Missouri	1887
Arizona State Hospital, Phoenix, Arizona	1887
Logansport State Hospital, Logansport, Indiana	1888
Clarinda State Hospital, Clarinda, Iowa	1888
Agnews State Hospital, Agnew, California	1888
Norfolk State Hospital, Norfolk, Nebraska	1888
Insane Department, Men's Reformatory, Anamosa, Iowa	1888
Western State Hospital, Western State Hospital (Bolivar), Tennessee	1889
Hastings State Hospital, Ingleside, Nebraska	1889
Wyoming State Hospital, Evanston, Wyoming	1889
Delaware State Hospital, Farnhurst, Delaware	1889
Evansville State Hospital, Evansville, Indiana	1890
Richmond State Hospital, Richmond, Indiana	1890
Fergus Falls State Hospital, Fergus Falls, Minnesota	1890
St. Lawrence State Hospital, Ogdensburg, New York	1890
Vermont State Hospital for the Insane, Waterbury, Vermont	1891
Illinois Security Hospital, Menard, Illinois	1891
Eastern State Hospital, Medical Lake, Washington	1891
New Mexico State Hospital, Las Vegas, New Mexico	(?)1891

° See footnote "d."

San Antonio State Hospital, San Antonio, Texas	1892
Mayview State Hospital, Mayview, Pennsylvania ^p	(?)1893
Spencer State Hospital, Spencer, West Virginia	1893
Mendocino State Hospital, Talmage, California	1893
Patton State Hospital, Patton, California	1893
Wernersville State Hospital, Wernersville, Pennsylvania	1893
Bridgewater State Hospital, State Farm, Massachusetts ^q	1895
Newberry State Hospital, Newberry, Michigan	1895
Central Oklahoma State Hospital, Norman, Oklahoma ^r	1895
Medfield State Hospital, Medfield, Massachusetts	1896
Springfield State Hospital, Sykesville, Maryland	1896
Massillon State Hospital, Massillon, Ohio	1898
Gowanda State Homeopathic Hospital, Helmuth, New York	1898
East Moline State Hospital, East Moline, Illinois	1898
Hollidaysburg State Hospital, Hollidaysburg, Pennsylvania ^s	(?)1898
Anoka State Hospital, Anoka, Minnesota	1900
Embreeville State Hospital, Embreeville, Pennsylvania ^t	1900
Dannemora State Hospital, Dannemora, New York	1900
Retreat State Hospital, Retreat, Pennsylvania ^u	1900
Hastings State Hospital, Hastings, Minnesota	1900
Somerset State Hospital, Somerset, Pennsylvania ^v	(?)1900
Central Islip State Hospital, Central Islip, New York ^w	1900
Bangor State Hospital, Bangor, Maine	1901
Huntington State Hospital, Huntington, West Virginia	1901

^p Originally the "Pittsburg City Home and Hospitals," the institution was turned over to the State of Pennsylvania August 1, 1941. Personal correspondence with the Bureau of Mental Health, Pennsylvania.

^q Although established as a separate institution in 1895, it was originally part of the Bridgewater State Almshouse which had maintained since 1886 a separate department for the criminal insane Hurd, *op. cit.*, II, 694.

^r From 1895 to 1915 the institution was privately owned, but subsidized by the State of Oklahoma; in the latter year the buildings were purchased by the State *Ibid.*, III, 364

^s Originally the "Blair County Hospital for the Insane", the State of Pennsylvania assumed control on September 1, 1941. Personal correspondence with the Bureau of Mental Health, Pennsylvania.

^t Originally the "Chester County Hospital for the Insane", the State of Pennsylvania assumed control on October 1, 1941. Personal correspondence with the Bureau of Mental Health, Pennsylvania.

^u Although now wholly supported by the State the matter of final transfer from County to State control was still under discussion in July, 1943. Personal correspondence with the Bureau of Mental Health, Pennsylvania

^v Originally the "Somerset County Home and Hospital", the State of Pennsylvania assumed control on September 1, 1941. Personal correspondence with the Bureau of Mental Health, Pennsylvania

^w Opened in 1889 as part of the New York City Asylum (later the Manhattan State Hospital), it became a separate institution in 1900. Hurd, *op. cit.*, III, 227.

Searcy Hospital, Mount Vernon, Alabama	1901
Cherokee State Hospital, Cherokee, Iowa	1902
Peoria State Hospital, Peoria, Illinois	1902
Gardner State Hospital, Gardner, Massachusetts	1902
State Hospital No. 4, Farmington, Missouri	1903
Norwich State Hospital, Norwich, Connecticut	1904
Foxboro State Hospital, Foxboro, Massachusetts	1905
Central Louisiana State Hospital, Pineville, Louisiana	1906
State Hospital, North, Orofino, Idaho	1906
Western Oklahoma Hospital, Supply, Oklahoma	1908

Madison State Hospital, North Madison, Indiana	1910
Northern State Hospital, Sedro Woolley, Washington	1911
Crownsville State Hospital, Crownsville, Maryland	1911
Blakely State Hospital, Olyphant, Pennsylvania ^a	(?)1911
Allentown State Hospital, Allentown, Pennsylvania	1912
Farview State Hospital, Waymart, Pennsylvania	1912
Indiana Hospital for Insane Criminals, Michigan City, Indiana	1912
Eastern Oregon State Hospital, Pendleton, Oregon	1913
Eastern Shore State Hospital, Cambridge, Maryland	1913
Eastern Oklahoma Hospital, Vinita, Oklahoma	1913
Central State Hospital, Waupun, Wisconsin	1914
Larned State Hospital, Larned, Kansas	1914
Alton State Hospital, Alton, Illinois	1914
Lima State Hospital, Lima, Ohio	1915
Norwalk State Hospital, Norwalk, California	1916
Willmar State Hospital, Willmar, Minnesota	1917
Rusk State Hospital, Rusk, Texas	1919
Torrance State Hospital, Torrance, Pennsylvania	(?)1919

Ransom State Hospital, Ransom, Pennsylvania ^a	(?)1921
Wichita Falls State Hospital, Wichita Falls, Texas	1922
Harlem Valley State Hospital, Wingdale, New York	1924
Lakin State Hospital, Lakin, West Virginia	1926
Manteno State Hospital, Manteno, Illinois	(?)1929

Metropolitan State Hospital, Waltham, Massachusetts	1930
Marcy State Hospital, Marcy, New York [*]	1931

^a Although now wholly supported by the State the matter of final transfer from County to State control was still under discussion in July, 1943. Personal correspondence with the Bureau of Mental Health, Pennsylvania.

^{*} From 1923 to 1931 this institution was a subsidiary of the Utica State Hospital *Annual Report Marcy State Hospital, 1942*, p. 45; *Handbook, State of New York Department of Mental Hygiene, 1942*, p. 37

New Jersey State Hospital, Marlboro, New Jersey	1931
Pilgrim State Hospital, Brentwood, New York	1931
Rockland State Hospital, Orangeburg, New York	1931
Ypsilanti State Hospital, Ypsilanti, Michigan	1931
DeJarnette State Sanatorium, Staunton, Virginia	1932
Fairfield State Hospital, Newtown, Connecticut	1933
State Hospital for Negro Insane, Taft, Oklahoma	(?) 1934
Creedmoor State Hospital, Queens Village, New York ⁷	1935
Psychiatric Division, Illinois State Penitentiary, Menard, Illinois	1935
Camarillo State Hospital, Camarillo, California	1936
Moose Lake State Hospital, Moose Lake, Minnesota	1938
Hawthornden State Hospital, Macedonia, Ohio ⁸	1938
Big Spring State Hospital, Big Spring, Texas	1939

*State Psychopathic Hospitals**Date of
Opening*

Boston Psychopathic Hospital, Boston, Massachusetts ^a	1912
Iowa State Psychopathic Hospital, Iowa City, Iowa	1920
Colorado Psychopathic Hospital, Denver, Colorado	1925
New York State Psychiatric Institute and Hospital, New York City, New York	1929
Syracuse Psychopathic Hospital, Syracuse, New York	1930
Galveston State Psychopathic Hospital, Galveston, Texas	1931
Illinois Neuropsychiatric Institute, Chicago, Illinois ^b	1931
Western State Psychiatric Hospital, Pittsburgh, Pennsylvania	1942
Langley Porter Clinic, San Francisco, California	1943

⁷ From 1912 to 1935 the Creedmoor Division was a unit of the Long Island State Hospital (later Brooklyn State Hospital), in 1935 it became a separate institution Hurd, *op. cit.*, III, 214.

⁸ From 1923 to 1938 this institution was a subsidiary of the Cleveland State Hospital. In 1938 it was made an independent institution. Department of Public Welfare, Ohio, Statistical Report for Year Ending December 31, 1938.

^a Part of the Boston State Hospital from 1912 to 1920, became a separate institution in 1920 U. S. Bureau of the Census, *Patients in Hospitals for Mental Disease, 1923*, p. 13.

^b In 1933 the old State Psychopathic Institute of the Department of Public Welfare, founded in 1907, was amalgamated with the Psychiatric Division of the Research and Educational Hospitals, opened in 1931, and remained the Psychiatric Institute of the Research and Educational Hospitals. Annual Report of the Department of Public Welfare, Illinois, June 30, 1940, p. 219.

<i>County Mental Institutions</i>	<i>Date of Opening*</i>
Grant County Asylum, Lancaster, Wisconsin	1847
Des Moines County Home, Burlington, Iowa	1850
Walworth County Asylum for the Insane, Elkhorn, Wisconsin	1852
Jefferson County Asylum for Chronic Insane, Jefferson, Wisconsin	1856
Columbia County Asylum, Wyoena, Wisconsin	1858
Dodge County Asylum and Home, Juneau, Wisconsin	1860
Eloise Hospital, Eloise, Michigan	1869
Essex County Hospital, Cedar Grove, New Jersey	1872
Green County Asylum, Monroe, Wisconsin	1875
Camden County Hospital for Mental Diseases, Grenloch, New Jersey	1879
Polk County Hospital for Insane, Des Moines, Iowa	1879
Milwaukee County Hospital for Mental Diseases, Wauwatosa, Wisconsin	1880
Sheboygan County Hospital for Chronic Insane, Sheboygan, Wisconsin	1882
Dane County Asylum for Chronic Insane, Verona, Wisconsin	1883
Manitowoc County Insane Asylum, Manitowoc, Wisconsin	1885
Fond du Lac County Asylum, Fond du Lac, Wisconsin	1887
Iowa County Insane Asylum, Dodgeville, Wisconsin	1887
Rock County Hospital, Janesville, Wisconsin	1887
Sauk County Home and Asylum, Reedsburg, Wisconsin	1887
Brown County Insane Asylum, Green Bay, Wisconsin	1888
La Crosse County Asylum for Insane, West Salem, Wisconsin	1888
Outagamie County Asylum, Appleton, Wisconsin	1888
Rancho Los Amigos (Psychopathic Unit), Hondo, California	1888
Vernon County Asylum, Viroqua, Wisconsin	1888
Sylvan Retreat, Cumberland, Maryland	1888
Milwaukee County Asylum for Chronic Insane, Wauwatosa, Wisconsin	1889
Racine County Asylum, Racine, Wisconsin	1889
Dunn County Asylum, Menomonie, Wisconsin	1892
Davidson County Hospital, Nashville, Tennessee	1893
Marathon County Asylum for Chronic Insane, Wausau, Wisconsin	1893
Hudson County Hospital for Mental Diseases, Secaucus, New Jersey	1894

* "Date of Opening" as entered is usually the date reported by the institution itself in answer to the query of the American Medical Association. In many instances it was not possible to check this date with other sources.

Winnebago County Asylum, Winnebago, Wisconsin	1894
Chippewa County Asylum, Chippewa Falls, Wisconsin	1895
Atlantic County Hospital for Mental Diseases, Northfield, New Jersey	1896
Richland County Asylum for Insane, Richland Center, Wisconsin	1896
St. Croix County Asylum, New Richmond, Wisconsin	1896
Clayton County Hospital, Elkader, Iowa	1898
Washington County Asylum for Chronic Insane, West Bend, Wisconsin	1898
Trempealeau County Asylum, Whitehall, Wisconsin	1899
Burlington County Hospital for the Insane, New Lisbon, New Jersey	1900
Cumberland County Hospital for Insane, Bridgeton, New Jersey	1900
Eau Claire County Insane Asylum, Eau Claire, Wisconsin	1901
Waukesha County Asylum for Chronic Insane, Waukesha, Wisconsin	1902
Waupaca County Insane Asylum, Weyauwega, Wisconsin	1902
Monroe County Insane Asylum, Sparta, Wisconsin	1903
Marinette County Insane Asylum, Peshtigo, Wisconsin	1906
Douglas County Asylum, Itasca, Wisconsin	1909
Wood County Asylum for Chronic Insane, Marshfield, Wisconsin	1911
Shawano County Insane Asylum, Shawano, Wisconsin	1913
Douglas County Sanatorium (for Tuberculous Insane), Itasca, Wisconsin	1914
Clark County Hospital, Owen, Wisconsin	1922
William L. Bork Memorial Hospital, Chattanooga, Tennessee	1929

County Mental Institutions—Date of Opening Unknown

Edgmoor Farm (Psychopathic Unit), Santee, California
Laguna Honda Home (Psychopathic Unit), San Francisco, California
Adair County Home, Iowa
Allamakee County Home, Waukon, Iowa
Black Hawk County Home, Waterloo, Iowa
Boone County Home, Boone, Iowa
Bremer County Home, Waverly, Iowa
Buchanan County Home, Independence, Iowa
Butler County Home, Iowa
Cass County Home, Iowa
Cedar County Home, Tipton, Iowa
Cerro Gordo County Home, Mason City, Iowa
Cherokee County Home, Cherokee, Iowa
Chickasaw County Home, New Hampton, Iowa
Clinton County Home, Charlotte, Iowa

Dallas County Home, Adel, Iowa
Decatur County Home, Leon, Iowa
Delaware County Home, Delhi, Iowa
Fayette County Home, Iowa
Floyd County Home, Floyd, Iowa
Grundy County Home, Grundy Center, Iowa
Guthrie County Home, Iowa
Hamilton County Home, Webster City, Iowa
Hancock County Home, Garner, Iowa
Henry County Home, Mt. Pleasant, Iowa
Iowa County Home, Iowa
Jackson County Home, Maquoketa, Iowa
Jasper County Home, Newton, Iowa
Jefferson County Home, Fairfield, Iowa
Johnson County Home, Iowa City, Iowa
Jones County Home, Anamosa, Iowa
Keokuk County Home, Sigourney, Iowa
Kossuth County Home, Iowa
Lee County Home, Keokuk, Iowa
Linn County Home, Marion, Iowa
Louisa County Home, Wapello, Iowa
Lucas County Home, Chariton, Iowa
Madison County Home, Winterset, Iowa
Mahaska County Home, Oskaloosa, Iowa
Marion County Home, Knoxville, Iowa
Marshall County Home, Marshalltown, Iowa
Mitchell County Home, Iowa
Monroe County Home, Albia, Iowa
Montgomery County Home, Red Oak, Iowa
Muscatine County Home, Muscatine, Iowa
O'Brien County Home, Primghar, Iowa
Pocahontas County Home, Iowa
Poweshiek County Home, Montezuma, Iowa
Sioux County Home, Orange City, Iowa
Story County Home, Nevada, Iowa
Tama County Home, Toledo, Iowa
Union County Home, Creston, Iowa
Van Buren County Home, Keosauqua, Iowa
Wapello County Home, Ottumwa, Iowa
Washington County Home, Washington, Iowa
Wayne County Home, Corydon, Iowa
Webster County Home, Fort Dodge, Iowa
Winnebago County Home, Forest City, Iowa
Winneshek County Home, Decorah, Iowa

Woodbury County Home, Sioux City, Iowa
 George Maloney Home, Knoxville, Tennessee
 Giles County Asylum, Pulaski, Tennessee
 Harris County Psychopathic Ward, Houston, Texas

<i>City Mental Institutions</i>	<i>Date of Opening*</i>
Baltimore City Hospitals (Psychopathic Unit), Baltimore, Maryland	1865
City Sanitarium, St. Louis, Missouri	1869
Cleveland City Infirmary and Chronic Hospital, Warrensville, Ohio	1903
City Hospital for Mental Diseases, New Orleans, Louisiana	1911
Hillside Home and Hospital, Bridgeport, Connecticut	1914

Town Mental Institution—Date of Opening Unknown

Stafford Town Home, Stafford, Connecticut

<i>Mental Institutions under the Veterans' Administration</i>	<i>Date of Opening†</i>
Palo Alto, California	1919
Perry Point, Maryland	1919
Knoxville, Iowa	1920
Augusta, Georgia	1920
Veterans Admin. Hospital (Marion), Indiana*	1921
Gulfport, Mississippi	1921
Veterans Admin. Facility (North Little Rock), Arkansas	1921
Fort Lyon, Colorado	1922
Sheridan, Wyoming	1922
American Lake, Washington	1924
Northampton, Massachusetts	1924
Chillicothe, Ohio	1924
St. Cloud, Minnesota	1924
Fort Custer, Michigan	1924
Downey, Illinois	1926
Northport, New York	1928

* "Date of Opening" as entered is usually the date reported by the institution itself in answer to the query of the American Medical Association. In many instances it was not possible to check this date with other sources.

† The date on which the hospital first began caring for mental patients was furnished by the Veterans' Administration

* This institution opened as a Soldiers' Home in 1890, it was converted to a neuropsychiatric hospital in 1921, but not transferred to the control of the Veterans' Administration until 1930. Reply of institution to query of the American Medical Association, and personal correspondence with the Veterans' Administration.

Bedford, Massachusetts	1928
Coatesville, Pennsylvania	1930
Lyons, New Jersey	1930
Waco, Texas	1932
Canandaigua, New York	1933
Lexington, Kentucky	1933
Tuskegee, Alabama	1935
Roanoke, Virginia	1935
Danville, Illinois	1935
Mendota, Wisconsin ^b	1937
Roseburg, Oregon	1937
Murfreesboro, Tennessee	1940
Tuscaloosa, Alabama	1940

U. S. Public Health Service Mental Institution

U. S. Public Health Service Hospital, Fort Worth, Texas ^a	1938
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Church Nervous and Mental Institutions

	<i>Date of Opening*</i>
Mount Hope Retreat, Baltimore, Maryland	1840
St. Vincent's Sanitarium, St. Louis, Missouri	1858
St. Joseph's Retreat, Dearborn, Michigan	1860
De Paul Sanitarium, New Orleans, Louisiana	1865
St. Vincent's Retreat, Harrison, New York	1879
Alexian Brothers Hospital, Oshkosh, Wisconsin	1879
St. Bernard's Hospital, Council Bluffs, Iowa	1887
St. Joseph Sanitarium, Dubuque, Iowa	1887
Immanuel Deaconess Institute—Invalid Home, Omaha, Nebraska	1897
St. Mary's Hill, Milwaukee, Wisconsin	1912
Mt. St. Agnes Sanitarium, Louisville, Kentucky	1913
Mercyville Sanitarium, Aurora, Illinois	1915

^b Leased from State of Wisconsin, January, 1937. Originally the "Wisconsin Memorial Hospital," established in 1921 for the care of mentally ill servicemen. Bernette O. Odegard and George M. Keith, *A History of the State Board of Control of Wisconsin and the State Institutions, 1849-1939* (Madison, Wisconsin, The State Board of Control), p. 169.

^a Planned originally for narcotic patients, this hospital now cares almost exclusively for psychotics. Those admitted are government beneficiaries of various classes, the same classes as are admitted to St. Elizabeths Hospital, Washington, with the exception of District patients.

* "Date of Opening" as entered is usually the date reported by the institution itself in answer to the query of the American Medical Association. In many instances it was not possible to check this date with other sources.

Mercywood Neuropsychiatric Hospital, Ann Arbor, Michigan	1925
Mt Mercy Sanitarium, Hammond, Indiana	1928
Nazareth Sanatorium, Albuquerque, New Mexico	1938
Mt. Mercy Sanitarium, Dyer, Indiana	1942

<i>Nervous and Mental Institutions, Nonprofit Associations</i>	<i>Date of Opening*</i>
Pennsylvania Hospital. The West Philadelphia Department, Philadelphia, Pennsylvania ^a	1752
New York Hospital—Westchester Division, White Plains, New York ^b	1791
Friends Hospital, Philadelphia, Pennsylvania	1817
McLean Hospital, Belmont, Massachusetts	1818
The Institute of Living, Hartford, Connecticut	1824
Brattleboro Retreat, Brattleboro, Vermont	1836
Butler Hospital, Providence, Rhode Island	1847
Marshall Sanitarium, Troy, New York	1851
Dixmont Hospital, Dixmont, Pennsylvania ^c	1853
Sheppard and Enoch Pratt Hospital, Towson, Maryland	1891
Fair Oaks Villa Sanitarium, Cuyahoga Falls, Ohio	1894
Highland Hospital, Asheville, North Carolina ^d	1904
Rogers Memorial Sanitarium, Oconomowoc, Wisconsin	1906
Christian Sanatorium, Midland Park, New Jersey	1911
Christian Psychopathic Hospital, Grand Rapids, Michigan	1911
Resthaven, Los Angeles, California	1912
Homewood Hospital, Minneapolis, Minnesota	1922

* "Date of Opening" as entered is usually the date reported by the institution itself in answer to the query of the American Medical Association. In many instances it was not possible to check this date with other sources.

^a The Department for the Insane in West Philadelphia was opened in 1841. Hurd, *op cit*, III, 400.

^b The department at the general hospital was discontinued and a separate building known as the Bloomingdale Asylum was opened in 1821. *Ibid*, III, 133.

^c From 1853 to 1862 the insane patients were treated in the Western Pennsylvania Hospital, a general hospital, in 1862 a separate building at Dixmont Station opened, in 1905 this department was granted a separate charter and is now known as the Dixmont Hospital, having no connection whatever with the Western Pennsylvania Hospital at Pittsburgh. *Ibid.*, III, 456.

^d The institution was presented to Duke University by Dr. Carroll and accepted by the University April 18, 1939, but leased for a five year period to the doctor in order to effect a gradual interchange of control. Reprint from the Asheville *Citizen Times*, April 23, 1931.

Neurological Hospital, Kansas City, Missouri	1923
The Southard School, Topeka, Kansas	1925
Hillside Hospital, Bellerose, New York	1927
Miami Retreat, Miami, Florida	1927
Pinel Sanitarium, Chicago, Illinois	1931
Hoye's Sanitarium, Meridian, Mississippi	1935
Ingleside Home, Cleveland, Ohio	1935
Glenwood Hills Hospital, Minneapolis, Minnesota	1935
Philadelphia Psychiatric Hospital, Philadelphia, Pennsylvania	1937
Jean G. McCracken Home, Wilmar, California	(?)
Jewish Home for the Aged, Inc., New Haven, Connecticut	(?)
Ingleside Home—Chardon Branch, Chardon, Ohio	(?)

JOHN C. WHITEHORN

A CENTURY OF PSYCHIATRIC RESEARCH
IN AMERICA

IN THE perspective of a century of psychiatric development in America, a convenient point of departure for the discussion of research is provided by the extraordinary address delivered to the American Medico-Psychological Association on May 16, 1894, by Dr. S. Weir Mitchell.¹ At the age of sixty-four this distinguished and learned neurologist and literary artist, then a commanding figure in American medicine, took the occasion of the fiftieth anniversary of the Association to administer a blistering verbal chastisement to the organized psychiatrists of that day. Dr. Mitchell said, among other things:

Once we spoke of asylums with respect, it is not so now. We, neurologists, think you have fallen behind us, and this opinion is gaining ground outside of our own ranks, and is, in part at least, your own fault. . . . Where . . . are your careful scientific reports? . . . You live alone, uncriticized, unquestioned, out of the healthy conflicts and honest rivalries which keep us [neurologists] up to the mark of the fullest possible competence.

Dr. Mitchell then sketched briefly his ideal hospital, designed and organized primarily to stimulate and encourage scientific investigation and progress.

This historic scolding may have served in some measure as an irritating stimulus, but the record of actual progress indicates that it did not well reflect the actual state of scientific investigation in psychiatry in the nineties, nor did it very effectively set the pattern for the main lines of significant psychiatric research in the years that followed. American psychiatrists have made definite and distinctive scientific contributions during the last fifty years, but the distinctively American contributions have been more definitely toward psychobiological understanding and the study of personal relationships than along the neurological lines prescribed by S. Weir Mitchell.

At the national psychiatric convention at Denver, in the year following Mitchell's diatribe, the presidential address was given by Dr. Edward Cowles;² some of Mitchell's criticisms were refuted, with most pointed

¹ *Journal of Nervous and Mental Disease*, XXI (1894), 413-438 (In the available volume, the address occupies a special repaginated insert)

² "The Advancement of Psychiatry in America," *Am. J. Insanity*, LII (1895), 364-386.

reference to the organization and management of hospitals. Perhaps the most definite, though indirect, reply from Cowles to Mitchell on the issue of psychiatric research was the account,³ in another portion of the same volume of the *Journal* in which the presidential address appeared, of the "new" McLean Hospital. Cowles was medical superintendent of the Hospital; the article tells of the provision made for intensive laboratory research in the basic medical sciences of pathology, physiology, and biochemistry as related to psychiatry.

It is an interesting indication of the direction of thought at that period that the major emphasis in this pioneering enterprise was put upon physiology and biochemistry—the study of the living, rather than of tissues post-mortem. This direction of thought was given even more significant emphasis by a young investigator, Adolf Meyer, then in transition from Kankakee to Worcester, who insisted upon adequate studies of the living, functioning patient as the foundation of psychiatric research.

The scientific frame of reference for investigation in medicine was at that period undergoing change. The cellular doctrines of Virchow had dominated pathology for the larger part of the nineteenth century; bacteriological concepts had won a supplementary role during the last two decades, chemical concepts were now gaining increasing consideration. For example, Vaughn and Novy wrote on ptomaines and leucomaines in 1888; Baumann prepared iodothyron in 1896; Abel isolated epinephrin in 1898. Cowles was well to the front in medical thought in supporting biochemical investigation. The neurasthenia concept of Van Deusen and Beard played an important part at McLean in determining Cowles' support⁴ of biochemical study⁵ and of August Hoch's studies on fatigue.

At about the turn of the century, Cowles obtained the services of a master of biochemical technique, Otto Folin, and of his young assistant Philip A. Shaffer, he supplied them with the means and the opportunity for applying the most valid known methods, and for developing new

³ Hurd, "The New McLean Hospital," *Am. J. Insanity*, LII (1895), 477-502, see also G. Stanley Hall, "Laboratory of the McLean Hospital," *Am. J. Insanity*, LI (1894), 358-364.

⁴ Cowles, *Am. J. Insanity*, LI (1894), 10-22.

⁵ Cowles was evidently impressed by Mitchell's little treatise *Fat and Blood* (1877), for even in 1921 six separate copies of this book were on the shelves of the several departmental libraries at McLean. But Cowles's interest in chemical aspects of medicine must have had a still earlier origin, for in the sixties he possessed an English translation of Justus von Liebig's *Chemistry in Its Applications to Agriculture and Physiology*.

methods, for the study of metabolism in the mentally ill. The publication of Folin's studies⁶ constituted a solid and enduring contribution to scientific research in psychiatry. His findings were negative and therefore disappointing, but they tended to check the more rash speculations on the metabolic etiology of psychoses, and on metabolic theories of their therapy.

Another event significant for psychiatric research in the year following Weir Mitchell's address was the organization of the Association of Assistant Hospital Physicians,⁷ aimed at the discussion of scientific rather than administrative problems. The secretary of this scientifically minded group was Adolf Meyer of Kankakee, Illinois. Meyer moved that same year to Worcester, Mass., still as a state hospital pathologist, but with the significant determination to focus careful study on the living patients, rather than to confine scientific study to the laboratory. His exacting clinical standards of study brought to light the singular personality of many patients of the dementia praecox group and led him to formulate the significance of bad mental habits in the development of that type of disorder.⁸

The half century of the Association which preceded Weir Mitchell's scolding had not been marked in America by any outstanding psychiatric "research" in the sense of specific scientific discoveries, but there had been progress toward a sober administrative responsibility, fostered by the original Association. The growing practice of lifelong devotion to psychiatry as a professional career gave perspective and maturity to the men engaged in the care and treatment of the insane. An enlightened and common-sense, though diffuse, appreciation of the practice involved in what had earlier been called "moral management" came to temper the crusading hostilities between protagonists and antagonists of "non-restraint." The hullabaloo about "curability" found a fairly reasonable and sober settlement in Pliny Earle's accumulated studies, *The Curability of Insanity*, published in 1887—nearly fifty years after his first unsophisticated and overenthusiastic statisticizations.⁹ In the field of therapy, S. Weir Mitchell in his private practice developed the "rest cure." Spitzka, as a neurological consultant and frequent visitor to mental hospitals, acquired an extensive cross-sectional acquaintance with

⁶ *Am J Insanity*, LX (1903), 699-732, and LXI (1904), 300-364.

⁷ See *Am J Insanity*, LI (1894), 129, 144.

⁸ See Meyer, *British Med J*, II (1906), 757-760.

⁹ Deutsch, *The Mentally Ill in America* (New York, Doubleday Doran, 1937).

many patients as the personal foundation for his textbook on insanity;²⁰ in it he expressed sympathetic appreciation of the etiological importance of emotional reactions and their potential significance in prognosis, but in general he echoed the European authorities of the time, chiefly Krafft-Ebing.

During the first half century of the Association, medical research in general was not well supported or organized for systematic, progressive investigation. During the third quarter century, from 1894 to about 1919, research became a definite aim of psychiatric leaders. Institutions were built, laboratories were equipped, and men who had been trained in scientific methods were employed in them with the clearly defined aim of scientific investigation into the causes of insanity. In retrospect, it may seem that these research aims were somewhat too sharply defined in certain instances, with too complacent an assumption that the clinical field had been adequately and accurately surveyed, and that what remained to be done was merely the application of laboratory methods to the elucidation of causes, from which would flow naturally the rational modes of prevention and therapy. This quarter century had, therefore, a special importance because it set certain patterns for the institutional organization of research. Institutionalized presuppositions mold men's actions to a considerable degree, even in the relative freedom of research.

In a general way, we conceive of research now, in the fifth decade of the twentieth century, as the intentional effort to reexamine, critically and searchingly by scientific methods, the concepts currently accepted or tentatively considered. We hope for new ideas, too, but we recognize that there is no regular technique for generating them. The recruitment of persons with the capacity for constructive thinking is the primary means of progress in psychiatric research, as in other research. Today we are accustomed to employ tested methods of observation, experiment, and analysis. This means, in considerable measure, the development and use of research laboratories, for they house the instruments used and are ordinarily organized to protect the time and energy of the investigators in order to assure the continuity of thought and effort required for constructive work. Probably the two weakest points in this current style of research organization lie in the dangers of isolation: first, from the

²⁰ Spitzka, *Insanity, Its Classification, Diagnosis and Treatment* (New York, Bermingham and Co., 1883).

correlated basic sciences and, second, from significant clinical considerations.

In general medical research the first of these weak points has found its most general safeguard in a good library and in close affiliation with a university, the medical school, where most medical research is done, is now an integral part of a university. The most obvious safeguard for the second of these weak points is a hospital or clinic. At both places the vital relationships are established and maintained (or fail to be established and maintained) through informal human contacts with fellow workers. This is perhaps more strikingly true in psychiatric research than in other fields, because of the wide range of sciences which deal with the forces bearing upon human functioning and malfunctioning in the problems of mental disorder.

From this organizational point of view, the two decades following Weir Mitchell's address were of special interest because of the different types of research organization established and their influence, sooner or later, upon the continuity and perspective of psychiatric research. The pioneering McLean set-up has already been briefly considered. The financial resources of state governments were tapped for the New York Psychiatric Institute, and for the Psychopathic Hospital at Ann Arbor and at Boston. Private philanthropy helped to establish and endow the Henry Phipps Psychiatric Clinic in the Johns Hopkins University and Hospital. At a later period, Yale University, in its Institute for Human Relations, sought to coordinate a very broad research program including psychiatry. The increasing number and variety of research organizations have been thoughtfully described and considered in two recent publications of the National Committee for Mental Hygiene.

At the New York Pathological Institute van Gieson attempted a rather grandiloquent "Correlation of the Sciences,"²¹ but the enterprise was rescued from methodological futility by the influence of Adolf Meyer's strong common sense and by the clinical interests of August Hoch. Out of these influences grew the New York Psychiatric Institute and Hospital, which later found a secure home, fertile contacts, and a steadying load of clinical responsibility in its new and magnificent quarters at the Columbia-Presbyterian Medical Center.

The Psychopathic Hospital at Ann Arbor and at Boston and the

²¹ Van Giesen [sic], *J. Mental Sci.* XLIV (1898), 754-811

Henry Phipps Psychiatric Clinic at Baltimore were established from their beginnings (1906, 1912, and 1913, respectively) in intimate relationship with the teaching of medical students. They were teaching hospitals as well as research centers. From a recent analysis of the membership of the American Psychiatric Association by Clifton T. Perkins,¹² it appears that more of the graduates of the three schools concerned (Michigan, Harvard, and Johns Hopkins) have gone into psychiatry than those of any other medical schools. This function of recruitment has perhaps as great a potential importance for research as any other item on the research program. Particularly at the Phipps Clinic and at the Boston Psychopathic Hospital, Adolf Meyer and Elmer Southard stimulated and inspired numerous young psychiatrists who came to them for advanced study.

At the Phipps Clinic the distinctive leadership of Meyer shaped developments along two mutually supporting lines. First, Meyer persistently strove to gain scientific recognition of the functioning human being as the central feature in psychiatry, and in general medicine, too. He strove toward insuring a practical acknowledgment of, and a realistic dealing with, the psychological modes of human functioning. To this end he developed and taught, perfectionistically, a kind of philosophical orientation to psychiatry which came to be known as "psychobiology." Secondly, and correlatively, in the practical work of the clinic Meyer insisted upon a pluralistic and pragmatic collection of all available facts about a given patient as the basis for action, or inference. The voluminous case records so gathered became the main research material of the Phipps Clinic. In particular, Meyer objected to the inadequacy and deceptive implications of mere categorical diagnosis in psychiatry, and he sought instead to develop formulations of "reaction patterns" which would give appropriate consideration to the plasticity, the spontaneity, and the individuality of the patient. During this last half century of psychiatric research in America, Meyer exerted a profound and pervasive influence—not always dominant but always to be taken into consideration. This role of leadership was strengthened by his enormous erudition and by his perspicacity in recognizing and encouraging younger workers, wherever located, who exhibited an interest in and a grasp of vital psychiatric problems.

Among the methodological items indicative of the working aims of

¹² Personal communication, 1943

the Phipps Clinic may be noted the behavior chart developed by Kempf¹³ for the meticulously careful day-by-day notation of a patient's condition and conduct and, more significantly, the continued use of this chart by the nursing staff. Another characteristic innovation was the terminology of the *ergasias*, by which the reaction-pattern concepts were given special verbal expression. Perhaps it has been the very widespread acceptance of the spirit of these concepts which has made it unimportant that the verbalistic devices themselves did not gain wide circulation.

The outstanding research contributions to appear from the Ann Arbor Psychopathic Hospital were Bariett's studies on heredity and constitution.¹⁴ Raphael and other associates contributed cognate studies of metabolism, pharmacodynamic reactions, and physique.

The Boston Psychopathic Hospital had in succession as directors two of the most stimulating and brilliant of American psychiatrists—Southard and Campbell—whose effects on research are more noteworthy indirectly than directly. Perhaps the encouragement of research may have been hampered by the tremendous case load of the Boston Psychopathic as the receiving hospital for a large metropolitan region, with admissions rising to over 2,000 a year and an average patient-residence of about a week. The long-term study of neurosyphilis, started under Southard¹⁵ and continued under Harry Solomon, has been its most notable research contribution. Bowman, while at the Boston Psychopathic, maintained a steady stream of investigation; most significant were his studies of pre-psychotic personality,¹⁶ which indicated the failures in social and emotional maturation, both in the schizophrenic and affective groups.

Besides these institutions which had been specially organized to foster psychiatric research in the period closely following the turn of the century, other institutions devoted some of their resources to the same end. In a period of expansion under William Alanson White, St. Elizabeths Hospital (the Federal Government institution) built up an investigative program which far outranged the conceptions of its original pathologist, I. W. Blackburn. Private hospitals, such as McLean, Sheppard and Enoch Pratt, Bloomingdale (now the Westchester Division of the New York Hospital), and the Pennsylvania Hospital, fostered investigations along the lines of the special interests of staff members. Many state hospitals

¹³ *Am. J. Insanity*, LXXI (1914), 761

¹⁴ *Am. J. Psychiatry*, LXXXI (1924), 245-260.

¹⁵ Southard and Solomon, *Neurosyphilis* (Boston, W. M. Leonard, 1917)

¹⁶ Bowman, *Am. J. Orthopsychiatry*, IV (1934), 473-498.

established or maintained pathological laboratories as a gesture of scientific interest, but too often they were without adequate scientific personnel.

In many respects the period after the World War brought more radical developments and much more financial support to psychiatric research than any preceding period, but the quarter century after Weir Mitchell's address saw also a number of developments, not primarily of a research type, which strongly influenced the subsequent course of research.

The Binet-Simon yardstick for "mental age" measurement stimulated an extraordinary development of scientific methodology. Public attention was called to social problems relating to mental deficiency by H. H. Goddard in his studies of the Kallikak family,²⁷ and by others. Sterilization plans gave a poignantly practical significance to studies of heredity. William Healy brought a psychiatric perspective to bear on the problems of the juvenile delinquent. Southard and Miss Jarrett effected a significant working liaison between psychiatry and the professionally trained social worker. The war of 1914-1918 brought a new term, "shell-shock," which quickly exploded, but the compilation by Southard and the experience and insight of Schwab and others heightened professional curiosity about the emotional dynamics of war neuroses and gave much weight to "dynamic" considerations in subsequent research.

"Dynamic considerations" (a term which means, roughly speaking, the psychology of motivation), received a marked stimulus in America by Freud's visit to Clark University, and the organization of a psychoanalytic society. Psychoanalytic doctrines had able exponents in Brill, Frink, Jelliffe, and White; but to most American psychiatrists psychoanalysis remained a topic for cloak-room wise cracks or parlor discussions, and did not markedly influence the course of research until the postwar period, when growing numbers of American psychiatrists with psychoanalytic training and a number of European emigré psychoanalysts greatly increased the research applications of that method.

The national experiment of prohibition did not elicit much psychiatric investigation beyond a few statistical papers; since repeal, however, an active organization for research in problems of alcohol has been formed, much study has been done—particularly at Bellevue Hospital in New York City—a journal has been founded, and, most recently, a

²⁷ *The Kallikak Family* (New York, Macmillan, 1912).



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school has been established at Yale University. All this work has been done to promote scientific research into the human problems related to alcohol. Alcoholism and the psychoses are closely related phenomena of living, and of defeat in living. About one fifth of those admitted to mental hospitals have sought alcoholic solace in intemperate measure, and half of these are addicted to such a degree that the diagnostic classification of alcoholism as the primary factor is justified.¹⁸

Among the forces brought to bear upon psychiatric research in the quarter century after 1894, the National Committee for Mental Hygiene began to exert its pervasive influence in 1909. Although not founded primarily for research, its general stimulating influence elevated standards, encouraged investigative activities, and built a philanthropic interest which favored subsequent large investments by foundations in psychiatric education, training, and research. The Committee itself became the distributing and coördinating agency for grants for research on dementia praecox, with Nolan D. C. Lewis as field director, when the Supreme Council of the Northern Masonic Jurisdiction, under the leadership of Mr. Melvin Johnson, undertook to appropriate a considerable fund annually for the investigation of this disorder.

The third quarter century, just discussed above from the general viewpoint of research organization, was also notable for the substantial degree in which personality functions became the focus of psychiatric investigation.

It is a curious fact, often noted by other scientists when commenting on reports of psychiatric research, that it requires a long introduction to set the special subject in an operational perspective. "Everyone has to start from scratch all over again," is a typical criticism of psychiatric research. This stands in some contrast to many other biological and medical fields of study, where main lines and systematic orientations make the pertinence of a small *Arbeit* promptly apparent. This state of affairs in psychiatric discourse results in part from our relatively undeveloped knowledge of medical psychology as a mutually significant field of reference for various scientific investigators; but there is behind this a more profound source of discord and uncertainty in dealing with personal functions. Different human beings (including psychiatrists) have developed strong beliefs—diverse and contradictory beliefs²—about the na-

¹⁸ Dayton, *New Facts on Mental Disorders* (Springfield and Baltimore, Charles C. Thomas, 1940).

ture of human nature. Such prejudices, based on fragmentary experience and on emotional identifications with admired leaders, are a practical necessity in daily living, for one cannot function smoothly without some prejudgments; yet their tentative and fragmentary basis in experience is lost sight of in the human need for complete faith in something. Attitudes comparable to religious sectarianism arise in individuals as socially integrative supports in dealing with life's personal problems. Efforts at the scientific delineation of psychological principles in research investigations and discussions, when these go to any considerable depth, encounter these diverse articles of faith. Adversaries become aroused, they become meanly partisan and exhibitionistic, and the search for a consensus of experience drops out of consideration.

One reason why psychiatric research suffers in relatively large measure from this distemper lies in the inevitably personal character of its field of study. The classical escape from this trouble has been to ignore the facts of personal functioning and to focus exclusively on the impersonal. One gains thereby a greater chance for definiteness and measurability while risking the loss of significance, particularly in psychotherapy.

The third quarter century which opened in 1894 found American psychiatry predominantly organicist and impersonal in its scientific preoccupations; the close of the fourth quarter century in the present year (1944) finds so large and systematic a measure of practical interest in the personal that we in America now recognize "disorders of personality" as a practical synonym for psychiatry. This achievement is somewhat dimmed by shallow thinking about personality, and by insistent partisan dogmatism on the instinctual or social nature of the essential personality "structure"; but we have at any rate developed in considerable measure a scientific attitude, or at least a professional working attitude, which includes personal functioning as an inherently appropriate field for psychiatric study.

It is of some interest to note how two of the foremost leaders of our psychiatric investigation in this new direction dealt with the organicist tradition. In one of his early papers, White¹⁹ distinguished the "molecular" from the "molar" causes of cerebral malfunctioning—a well-nigh atomic dispersion of the rationalistically required lesion; thereafter he dealt quite directly with function. Of the various papers in which Meyer dealt with this matter, probably the most incisive and constructive was

¹⁹ W. A. White, *Am. J. Insanity*, L (1894), 530-537.

the one with the characteristically involved title, "Objective Psychology or Psychobiology with Subordination of the Medically Useless Contrast of Mental and Physical,"²⁰ in which he said: "As soon as mental attitudes and mental activities are accepted as definite functions of a living organism, mentation and behavior is treated as a real chapter of the natural history of man and animal, and psychology ceases to be a puzzle supposedly resisting the objective methods of science."

That this increased practical concern with the investigation of personal functions did not discourage an interest in the physiology and structure of the human organism is made evident in books written by two of the younger generation, Edward J. Kempf on *The Autonomic Functions and the Personality*,²¹ and Nolan D. C. Lewis on *The Constitutional Factors in Dementia Praecox*.²² Each of these investigators had worked closely with both Meyer and White.

In the organicist tradition, the outstanding psychiatric achievement as well as the final and conclusive link in the demonstration of the etiological role of syphilis in general paresis was Noguchi and Moore's demonstration of the spirochete in the brains of general paresis.²³

Reports of scientific investigations in psychiatric fields increased very greatly in number in the quarter century from 1919 to 1944, through the natural spread of individual interest and stimulation, through the increased enlightenment and sense of responsibility of hospital and government authorities, through the participation and support of medical schools and universities, and through the generous financial support of philanthropic individuals and foundations—particularly of the Rockefeller Foundation, which has put several million dollars into psychiatric education and research.

The difficulties in gaining and delineating a comprehensive view of these more recent research developments have been increased by the multiplication of avenues of publication and by the variety of other affiliations, which lead investigators of psychiatric problems to publish their reports in journals of biochemistry, physiology, sociology, and so on. From the standpoint of the reader of journals and the listener at scientific meetings there seems also to be a great deal of disjointed work, not followed up or brought into systematic relation with preceding or current

²⁰ *J Am Med. Assn*, LXV (1915), 860-863

²¹ New York, Nervous and Mental Disease Publishing Co., 1918

²² New York and Washington, Nervous and Mental Disease Publishing Co., 1923

²³ *J Exp Med*, XVII (1913), 232

work. In the long run, however, this lack of continuity in much of the published work may be merely a troublesome sign of a favorable condition—a reflection of the wider opportunities which give many workers a chance to try themselves in investigative lines and to strive for some brief distinction in research as a step toward professional advancement.

In the present brief survey, no complete account of all these endeavors is attempted.

The centers for persistent and continuous programs of psychiatric research were principally located in the wealthier states of the Atlantic seaboard. At St. Elizabeths Hospital, under White (who continued his active interest in the dynamic forces of the personality), Lewis and Freeman made constitutional considerations their special concern, and Karpman made intensive studies of criminals. Under Meyer's guidance at the Henry Phipps Psychiatric Clinic, Diethelm, Wertham, Katzenelbogen, Muncie, Richter, and Gantt maintained a steady program in which many participated. At the Pennsylvania Hospital, Bond, Strecker, and Farr maintained active research teamwork with younger staff members. At the Boston Psychopathic Hospital a considerable variety of topics engaged the interests of an active and changing staff. At Bloomingdale Hospital, Henry and Zilboorg contributed to physiological and psychoanalytic investigations, the latter showing special interest in childbirth, murder, and suicide. At the Sheppard and Enoch Pratt Hospital were Looney and Sullivan, and later Woolley. At McLean Hospital, Wells and later Lundholm continued their psychological studies, and Whitehorn began his combination of biochemical, physiological, and clinical investigations of emotional reactions and attitudes. In the Middle West, steady research programs under Barrett and Raphael continued into the thirties at the Ann Arbor Psychopathic Hospital (recently reorganized as the Neuropsychiatric Institute). At the Chicago State Hospital was Read, who later organized at the Elgin State Hospital a very active research program specially centered on shock therapy. At the newly founded Psychopathic Hospital in Iowa (Orton, Malamud, now at Worcester, and Lindemann) and in Colorado (Ebaugh), research was an integral part of the program. In the reorganized Hartford Retreat (later The Neuropsychiatric Institute and now The Institute for Living), Burlingame has recently been responsible for a service much appreciated by workers everywhere—the circulation of abstracts of recent publications in neurology and psychiatry.

In two of the older institutions a marked burst of activity has been notable. At the Psychiatric Institute in New York, sumptuously housed in the great new Medical Center, Carney Landis led in a very busy psychological program utilizing statistical and questionnaire methods and high-speed cinematic recording.²⁴ Flanders Dunbar, Daniels, and their collaborators, utilizing the patients in the Presbyterian Hospital, have made pioneer studies in "psychosomatic" medicine.²⁵ Under Nolan Lewis the clinical research activities of the Institute have been intensified, with Barrera and Pacella taking an active lead. Kallmann conducts there a current research on identical twins, using material in the state-wide hospital system, which should give a much needed certainty to the moot question of heredity as a determinant of schizophrenia. At the Worcester State Hospital, Roy Hoskins assembled a research group specially qualified for endocrinological and statistical studies, under the Memorial Foundation for Neuro-Endocrine Research. A great volume of studies on schizophrenia issued from this Worcester group. Perhaps their most significant demonstration was of a negative character. They showed that physiological and endocrinological abnormalities are of common occurrence in schizophrenic patients, as had earlier been demonstrated. By their combined efforts they showed also—more clearly than had been apparent in any other work—the scattered distribution of such abnormalities: that is, the lack of a consistent and specific pattern of physiological abnormality in the whole schizophrenic group, or in any clinical subgroup, unless it be characterized in very general terms as a disorder of homeostasis.²⁶ Of this group of workers Erickson, now at Eloise, Michigan, has since made significant advances in our knowledge of hypnosis,²⁷ D. Ewen Cameron, now at McGill, has written a second and much improved edition of a valuable treatise on *Objective and Experimental Psychiatry*,²⁸ Jellinek, now at Yale, is leading in research on problems of alcohol; and Angyal has made a significant attempt at a holistic or organismic formulation of the personality concept.²⁹

²⁴ Landis and Hunt, *The Startle Pattern* (New York, Farrar and Rinehart, 1939), Page, Landis, and Katz, *Am J Psychiatry*, XC (1934), 1213-1225

²⁵ Dunbar, *Emotions and Bodily Changes* (New York, Columbia Univ Press, 1935), see also *Am J Psychiatry*, XCI (1934), 541-562

²⁶ Hoskins and Jellinek, *Assn Res Nerv and Mental Dis*, XIV (1931), 211-233

²⁷ Erickson, *Psychosomatic Med*, V (1943), 51-70

²⁸ 2d ed., New York, Macmillan, 1941.

²⁹ Angyal, *Foundations for a Science of Personality* (New York, The Commonwealth Fund, 1941).

The Institute of Human Relations, set up at Yale in the late twenties, has attempted the most ambitious effort yet organized for the synthesis of psychiatry with other sciences of human nature for research purposes, but it is as yet without the hoped-for measure of collaborative success. Dodge and Kahn⁸⁰ collaborated in formulating the craving for superiority. Dollard and others have collaborated in a study of *Frustration and Aggression*.⁸¹ In general, however, investigation in the Institute has been pushed along individual lines: for example, the study of child behavior and maturation by Gesell and his associates⁸² and the studies by Gildea and his associates on blood sugar and blood lipoids as related to acute emotional disturbances and to the more enduring dispositional features of human nature

Centers of research have recently multiplied well-nigh beyond coherent accounting and characterization, although a notable attempt to keep abreast of such developments has been made by Samuel W. Hamilton and others for the National Committee for Mental Hygiene.

For newer organizations the city of Chicago is especially notable. The group at the University of Chicago (Slight, Masserman, Brosin, Carmichael, Kluver, Halstead), the Institute for Juvenile Research (H. Adler, Levy, Sherman), the University of Illinois group (Singer, and more recently Gerty, Gellhorn, Kraines) and the Michael Reese groups (Kasanin, now in Mt. Zion at San Francisco, Beck, Grinker) have already made significant contributions. The Institute for Psychoanalysis (Alexander, French, Saul, Benedek) has provided wide psychoanalytic stimulation and teaching, and is of significance for the special research interests of its leaders in problems of "psychosomatic" medicine—among them, peptic ulcer, hypertension, asthma.

Toronto, Cincinnati, Louisville, St. Louis, San Francisco, Galveston, and a number of other cities have been scenes of recent psychiatric developments, with research programs or potentialities.

At Harvard University a Psychological Clinic was established through the interest of Morton Prince, himself a highly stimulating student of personality disorders and an adept in the use of hypnosis.⁸⁴ Here much

⁸⁰ Dodge and Kahn, *Craving for Superiority* (New Haven, Yale Univ Press, 1931).

⁸¹ Dollard, Doob, Miller, Mowrer, and Sears, *Frustration and Aggression* (New Haven, Yale Univ Press, 1938).

⁸² Gesell and Amatruda, *Developmental Diagnosis* (New York, Hoeber, 1941)

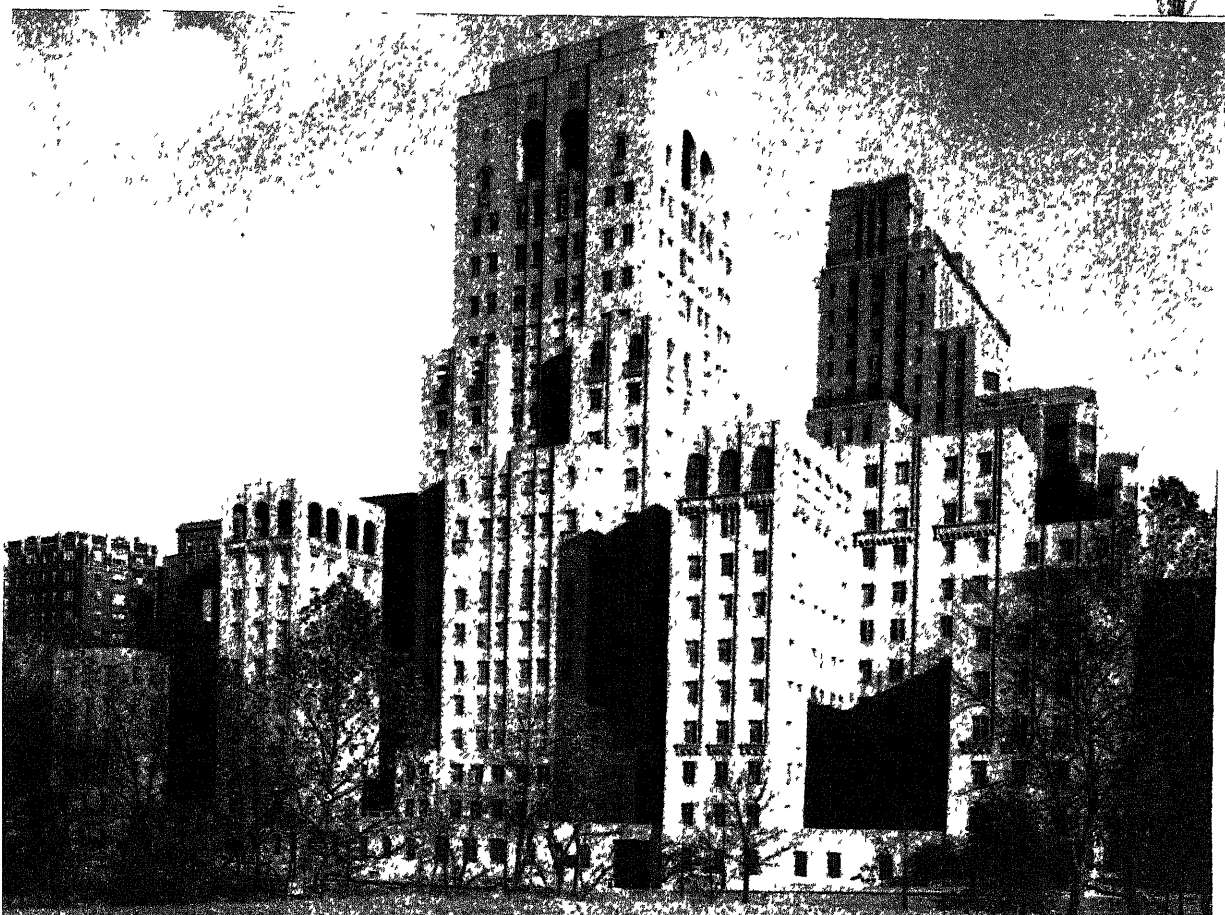
⁸³ Gildea, Mailhouse, and Morris, *Am. J. Psychiatry*, XCII (1935), 115, Gildea, Kahn, and Man, *Am J Psychiatry*, XCII (1936), 1247

⁸⁴ Prince, *The Dissociation of a Personality* (New York, Longmans, 1905)

ingenious investigation has been directed to the exploration of personality functions and the experimental study of dynamic human psychology, under the leadership of H. A. Murray.³⁵

The present and recent activities at Harvard illustrate the great diversity of scientific interests which have come to have an investigative bearing upon psychiatry, within one university organization, although with little formal integration. Murray's group concerns itself with the experimental validation of Freudian concepts. Lashley studies the cerebral cortex and behavioral capacities of rats. Allport develops a personalistic social psychology. Sheldon systematizes new formulations regarding the physical and mental constitution. Zipf, a philologist, studies schizophrenic language with Whitehorn, once a biochemist. The epilepsies are the special field of study for Cobb, Lennox, the Gibbsses, and Merritt and Putnam, resulting in a new formulation of this age-old problem as paroxysmal cerebral dysrhythmia, and a new and effective remedy, diphenylhydantoin. Cobb, Finesinger, and their collaborators established at the Massachusetts General Hospital a psychiatric service through which they investigate physiological psychology. Romano studies ward rounds psychiatrically. Myerson explores the potentialities of adrenergic and cholinergic drugs, "total push," and electroshock. Merrill Moore organizes statistical and clinical studies of alcoholism. The Davises study the electroencephalogram in the psychoses. D'Elseaux studies the acid-base equilibrium in neural and non-neural tissues. Stotz, following Folin and Whitehorn in the biochemical laboratory at McLean, studies the enzyme systems and the vitamins important in cerebral metabolism. Tillotson and Talbott study the metabolism at the very low body temperatures occurring during cryotherapy. Cecil Drinker begins to take an active part in the physiological studies of the psychoses. Denny-Brown continues his clinical studies of psychiatric considerations in post-traumatic conditions. Even in the business school the study of fatigue in industry under Mayo turns out to hinge largely on personal attitudes and substitutive reactions comparable to obsessions, which can be ameliorated by "interviewing," utilizing psychiatric principles. Campbell and Solomon, carrying the bulk of the clinical psychiatric teaching, continue their well-advanced studies on schizophrenia and general paresis.

³⁵ *Explorations in Personality* (New York, London, Toronto, Oxford Univ. Press, 1938).



NEW YORK PSYCHIATRIC INSTITUTE (OLD AND NEW)

This list of Harvard studies is incomplete. It is more extensive and diversified than in most centers of study, yet a somewhat comparable complexity of research in psychiatry may be noted at Johns Hopkins and at Columbia. The difficulties of evaluation and of synthetic integration have obviously increased enormously. Only a few lines of direction can be pointed out.

The earlier postwar years were characterized by a marked tendency on the part of enthusiastic psychiatrists toward expansion into many fields. In many ways there ensued much practical benefit, as in child welfare and pediatric practice, but there was relatively less basic research. Kanner's textbook³⁶ contributed a much-needed organization to the field of child psychiatry. Plant's thoughtful study³⁷ presented the fruits of a serious investigative attitude in dealing practically with personality development. David Levy has published extensive and significant papers on the role of the mother in the child's personality development and subsequent disorders.³⁸

Problems of delinquency and penology received much psychiatric study, with preliminary indications that these two fields might be greatly clarified by such psychiatric nosological concepts as mental deficiency and psychopathic personality. Stearns³⁹ in Massachusetts made notable practical efforts. Alexander later made psychoanalytic studies of some of Healy's cases.⁴⁰ There now prevails a somewhat more realistic appreciation that psychiatry's contributions to these problems of human nature lie more in the methodology of study than in prefabricated answers.

The immense territory of the psychoneuroses gradually became an accepted responsibility of psychiatry, not primarily by an expansive invasion of psychiatrists but rather by a complicated amalgamation of ideas and activities—a part of the general reorientation toward personality and its disorders. The discipline of psychiatry gained enormously thereby in the scope and significance of its scientific interests and concepts, and the discipline of neurology incidentally suffered a considerable constriction in its field of acknowledged competence. It would indeed seem

³⁶ *Child Psychiatry* (Springfield, Charles C Thomas, 1935)

³⁷ *Personality and the Cultural Pattern* (New York, Commonwealth Fund, 1937)

³⁸ *Psychiatry. Journal of the Biology and Pathology of Interpersonal Relations*, V (1942), 63 (Consult author-bibliography, p. 155)

³⁹ *Personality of Criminals* (Boston, Beacon Press, 1932).

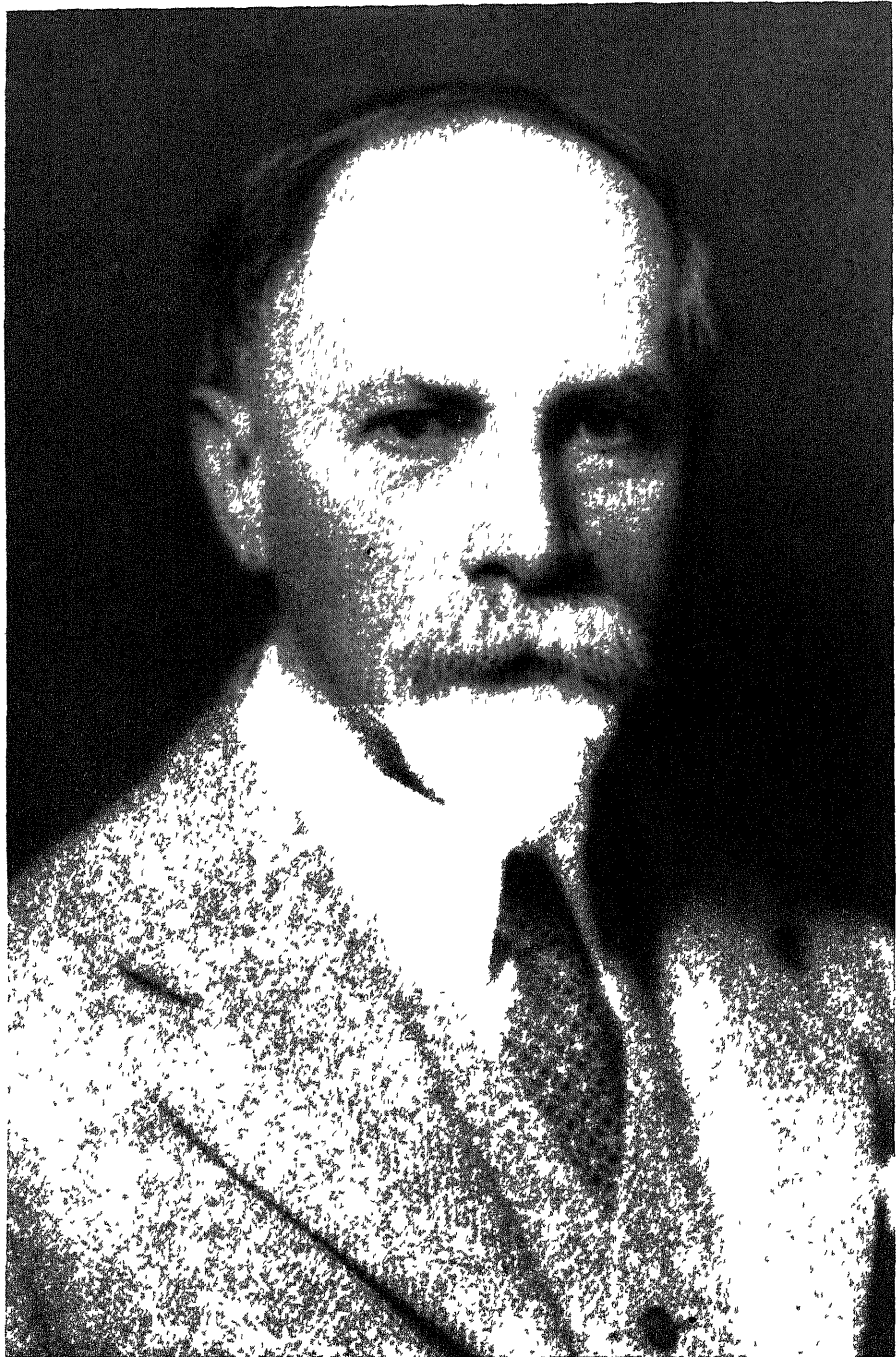
⁴⁰ Alexander and Healy, *Roots of Crime* (New York, Knopf, 1935).

strange to Weir Mitchell to see the expanding specialty of his day so sorely squeezed as it is today between the psychiatrists on one side and the neurosurgeons on the other. The complicated series of discoveries and the practical readjustments of attitude which produced this present amalgamation of the neuroses and psychoses into one broad field of professional specialization were not exclusively or even distinctively American in origin. They came about largely as an outgrowth of Freud's discoveries and insight into the dynamic psychology of the neuroses, in combination with Meyer's psychobiological insight into the psychoses.

Another field, now tentatively designated as psychosomatic medicine, is at present one of very active research and publication. Its main areas of concern lie in those clinical conditions which, although characterized by unquestioned malfunction or even lesions of specific organs or tissues, have been, in significant measure, dependent for their development upon emotional personality reactions of a persistent or neurotic nature. Psychosomatic illness may result from other etiological agencies and processes combined with an emotionally disturbed physiology. Flanders Dunbar's monumental compilation on *Emotions and Bodily Changes* is a significant landmark in developing a recognition of this field of study, and the new journal *Psychosomatic Medicine* provides an avenue for current publication. The scientific development of this field is beset with special difficulties of an organizational and ideological kind, since it closely concerns some of the most controversial and slippery concepts in medicine. There is considerable risk that the field may undergo too hasty a subdivision by organ systems into "specialties." Since personality considerations are the fundamentals here, it is a challenge to the psychiatric leadership in this development to guide it along sound lines of personality understanding. Among the most active investigators in this field have been Franz Alexander (peptic ulcer and asthma), Stanley Cobb (mucous colitis and arthritis), Harold Wolff (gastric disorders), Felix Deutsch, and Weiss and English.⁴

As for the reverse contributions, those from medicine to psychiatry, during this last quarter century, the most notable discoveries have been in the field of malnutrition. Pellagra has been checked by more adequate nutrition, particularly by treatment with the special vitamin nicotinic acid. Thiamine deficiency has been shown to have special importance

⁴ Weiss and English, *Psychosomatic Medicine* (Philadelphia and London, Saunders, 1943)



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in chronic alcoholic states—including Korsakow's syndrome. Interesting and fascinating possibilities have been opened by investigations of the part vitamins play in the enzyme systems of the brain. The psychiatric significance of these nutritional discoveries has not yet been fully elucidated.

In the field of metabolic disorders, Folling discovered a curious abnormality, the excretion of phenylpyruvic acid in the urine of certain imbeciles,⁴² a condition which appears to be hereditary according to Jervis's investigation.⁴³

During the thirties many psychiatrists in America were thrown into a feverish anticipation of great new discoveries by the phenomenal reports of success in the drug treatment of schizophrenia. Sakel, at Poetzl's clinic in Vienna, had reported extraordinarily high percentages of recovery in schizophrenic patients subjected to insulin hypoglycemia. The greatest enthusiasm was of course primarily oriented toward therapy, but the degree of specificity for this drug treatment, such as was at first claimed, had potentially radical significance in attempts to discover a specific organic cause for this type of psychosis. Extensive trials were made in many institutions and much investigation was carried out to determine, if possible, the mode of healing. From 1935 onward, scores of American workers contributed an extensive literature on the insulin treatment, most of the reports being in the three years 1936, 1937, and 1938.

Under the cautious analysis of an experienced psychiatrist like Earl Bond,⁴⁴ the insulin method of treatment has been found valuable. Four years after such treatment about 30 per cent of Bond's cases were "recovered or much improved," compared to recovery rates between 10 per cent and 20 per cent in his control cases five years after hospital treatment without insulin. The most remarkable feature of the insulin treatment is the relative promptness of a favorable reaction, about half of the cases treated showing recovery or much improvement by the end of a systematic course. Many relapse, however, which reduces the net gain; by more conservative management (not using insulin) the improvement or recovery may be more delayed, giving a rising rather than a falling percentage of recovery during successive years after admission. Some reports have been more favorable, others less favorable, as to the net value of

⁴² *Zeitschr. f. Physiol. Chem.*, CCXXVII (1934), 169

⁴³ *Arch. Neurol. and Psychiatry*, XXXVIII (1937), 944.

⁴⁴ Bond and Rivers, *Am. J. Psychiatry*, XCIX (1942), 201-202.

insulin therapy in schizophrenia. On the whole the results do not indicate that the hypoglycemic treatment has a degree of specificity sufficient to warrant belief in it as the key to resolving a supposed specific process causing schizophrenia. It appears rather that the use of insulin makes it possible to subject the patient to a series of remarkable experiences under the psychiatrist's control, which may be individually timed and utilized in a broadly organized plan of treatment.

In the attempts to discover the supposed physiological mode of cure in the insulin hypoglycemic treatment, Himwich and Gellhorn have especially distinguished themselves, without producing convincing proof for their conceptions of anoxemia or hypothalamic stimulation. Katzenelbogen and others have attributed some therapeutic efficacy to accessory features of the hypoglycemic experience, such as nursing attention, relation to physician, and so on.

Metrazol shock as devised by von Meduna, then of Budapest, and electroshock as devised by Cerletti of Rome, have been introduced and studied in this country, with a fair consensus of reports as to their frequent effectiveness in shortening the course of the affective disorders, as first reported by Bennett.⁴⁵

The shock treatments remain essentially empirical. We are without adequate rational understanding of their mode of helpfulness; the empiricists have posed a formidable problem for rational research. In addition the shock therapies have stimulated further researches regarding prognosis in the more severe types of psychosis, with the result that there has been a better validation, and a wider diffusion of knowledge, regarding the personality assets long known by the experienced psychiatrist to be important in individual prognosis.

Another radical innovation is surgical attack upon the frontal lobes, introduced in this country by Freeman and Watts.⁴⁶ It has been found useful in relieving the anxiety of chronic agitated patients, with less diminution of intellectual capacity than earlier theories of brain localization had led one to expect.

The intellectual functions involved in psychotic illness have been the special subject of numerous investigations, the most recent extensive study being that by Roe and Shakow.⁴⁷ In the general group of psychotic

⁴⁵ *Am J Med Sci*, CXCVIII (1939), 695-701.

⁴⁶ *Psychosurgery* (Springfield, Charles C Thomas, 1942)

⁴⁷ *Annals N Y Acad Sci*, XLII (1942), 361-490.

patients, as distinguished from those of mental deficiency, poor test performances appear to be secondary to the more sweeping disorder of personality and not a primary condition of any particular psychosis. Kasanin and Hanfmann⁴⁸ used the Vigotsky technique to investigate the alleged schizophrenic deficiency in concept formation, with somewhat equivocal results. Goldstein's test for abstract behavior and his concept of the organismic nature of reactions after brain injury have been invoked to explain the nature of the schizophrenic thinking disorder. As is clear from Norman Cameron's reports,⁴⁹ it is readily demonstrable, however, that schizophrenic patients may exhibit not only normal capacity for abstract behavior but marked proclivities thereto, which are difficult to test and to evaluate because of the schizophrenic's individualistic attitude.

During the last decade the Rorschach experiment has prompted much psychological study in psychiatry;⁵⁰ this was accelerated by European emigrés who were adept in the interpretation of Rorschach findings. What one reports seeing in a series of ink blots reveals in an extraordinary way the style of one's approach to life situations. The employment of unorganized stimuli, to which there is no "correct" response, thus permitting and even soliciting the spontaneous organizational reactivity of the subject, gives more abundant opportunity than do question and answer tests for the exhibition of personal characteristics. Such methods for studying personality have been called "projective."⁵¹ The thematic apperception test of H. A. Murray⁵² is similarly a projective test, since it solicits a response in which the themes of preoccupation of the subject are likely to be projected in the stories told about the simple pictures used as stimuli. The play technique with children belongs to the same type of study. These projective techniques have close similarities to the type of clinical attitude-study described by Whitehorn⁵³ for investigating personality functions. Indeed clinicians have long appreciated the fact that the most reliable avenue to a knowledge of the patient's personality

⁴⁸ *Conceptual Thinking in Schizophrenia* (New York, Nervous and Mental Disease Monographs, 1942).

⁴⁹ *J. Abnormal Social Psychol.*, XXXIV (1939), 265.

⁵⁰ S. J. Beck, *Introduction to the Rorschach Method* (Monograph No. 1, Am. Orthopsychiatric Assn., 1937); Klopfer, *Rorschach Research Exchange*, III (1939), 152; Bochner and Halpern, *The Clinical Application of the Rorschach Test* (New York, Grune and Stratton, 1942).

⁵¹ Frank, *J. Psychol.*, VIII (1939), 394.

⁵² See note 35, above.

⁵³ *Am. J. Psychiatry*, XCII (1935), 315

lies in observing the manner in which his personality is "projected" in spontaneous talk and activity.

In psychiatric research the methods of animal experimentation have never been so readily employed as in other fields of medicine—such as in bacteriology and nutrition and, more recently, in epidemiology and chemotherapy. But the development of the "experimental neurosis" by Pavlov's dog, when pushed to distinguish between circle and ellipse, has stimulated a considerable number of experimental studies of animal "neuroses" in America. The outstanding experimentalists have been Liddell, Gantt, Dworkin, Maier, and Masserman. In a recent monograph, Masserman⁵⁴ attempts more specifically than have others to bring the present knowledge of such reactions into significant perspective with our clinical insight into human personality disorders. As a formulation of the principles which he believes operate in animal, as well as human, disorders of behavior, he states:

(1) Behavior is motivated by the biological needs of the organism; (2) behavior is contingent upon, and adaptive to, the *meanings* of the "objective" and social environment as interpreted by the individual organism; (3) behavior relieves bodily tensions not only by direct but also by *substitutive, or symbolic*, activity; (4) when psychobiologic motivations or environmental meanings become excessively confused or conflictful, behavior correspondingly becomes abnormally indecisive, substitutive, diffusely symbolic, and biologically inefficient, i.e., "neurotic" or "psychotic" in expression.

The possibilities for gaining new light on mental disorders through statistical study have been brought to fruitful realization by Dayton⁵⁵ and Pollock⁵⁶ in the state hospital systems of Massachusetts and New York, respectively. The relationships between social environment and the major psychoses have been statistically investigated in Chicago and Providence by Faris and Dunham,⁵⁷ who report, for example, significantly different rates of incidence, much higher in the deteriorated and socially disorganized areas. More intimate firsthand psychiatric studies of communities have been undertaken by Lemkau in Baltimore and by Roth in rural Tennessee. Dayton's figures on the years 1917–1933 have shown fairly steady (slightly decreasing) admission rates for psychotic young adults, but marked increases in admission rates for the aged, this fact

⁵⁴ *Behavior and Neurosis* (Chicago, Univ. of Chicago Press, 1943)

⁵⁵ *New Facts on Mental Disorders* (Springfield and Baltimore, Charles C. Thomas, 1940)

⁵⁶ *Mental Disease and Social Welfare* (Utica, State Hospitals Press, 1941).

⁵⁷ *Mental Disorders in Urban Areas* (Chicago, Univ. of Chicago Press, 1939)

probably reflects some increased incidence of cerebral arteriosclerosis, but it is more largely attributable to an increasing utilization of state hospital care for the deteriorations and infirmities of the later decades of life, particularly in the cities. Dayton also clearly delineates that it is the cumulative load, rather than increasing incidence, which continues to fill and crowd the mental hospitals.

One of the outstanding research workers in American psychiatry was that curiously detached and independent figure Paul Schilder, who came in middle life from a distinguished scholarly career in Vienna, first to the Phipps Clinic and then to Bellevue Hospital. With extraordinary diligence and impetuous communicativeness, he attempted the difficult task of neuropsychiatric correlation, and by a curious fate he became best known for his treatise on psychotherapy, which was not his most effective talent. He had a wide influence by bringing to the attention of the younger American psychiatrists some of the clinical applications of the Gestalt school of psychology and of Husserl's "phenomenological" point of view. His appreciation of ideological misconceptions in the genesis and maintenance of neurotic behavior led him to urge group instruction as a practical psychotherapy. Perhaps his most distinctive contribution was the concept of the "body image."

In its increasingly serious attention to personal functioning as the point of convergence for psychiatric study, American psychiatry has received powerful stimulation and a significant sense of direction from Harry Stack Sullivan's studies and his White lectures,⁸⁸ in which he systematically developed the theme of interpersonal relationships. In the latter discussions he illuminated much of his earlier work by the elaboration of the theme of the parataxic illusions, derived from earlier anxiety experiences, which distort subsequent opportunities for personal growth and hinder mutual understanding. The publication *Psychiatry: Journal of the Biology and the Pathology of Interpersonal Relations* is itself an expression of Sullivan's major research insight and a vital force in present psychiatric practice and investigation.

Trigant Burrow has led a special group of students in "phyloanalytic" studies of human behavior and social maladjustment, eschewing in his special group for research purposes the customary medium of verbalistic symbols for significant revelation of meaning, and utilizing instead, within this very special community, the revelations of meaning physiologi-

⁸⁸ Sullivan, *Psychiatry*, III (1940), 1-116 (Consult author-bibliography, p. 172.)

cally perceptible. Burrow has particularly stressed the "ditensive" distortions of man's natural reactions through the dominance of visual-verbal part-function, resulting in the internal tensional disorders called neuroses. The difficulties of communicative technique have hindered the general psychiatric understanding of these publications.⁵⁹

Is the direction of present progress sufficiently clear to foreshadow future trends? Perhaps in a vague way, but not with certainty. We advance into the unknown by infiltration rather than parade; a certain incoherence is inherent and inevitable. The soundness of an advance in one direction and the untenability of an apparently equally good advance in another direction are alike concealed from immediate evaluation by mountainous regions of ignorance. It is the special aim of investigation to invade the terrain of ignorance, but a presumptuous and premature map of that terrain may, if false, be a serious hindrance to successful further advance.

Granting, then, that there are difficulties and dangers in surveying the direction of current trends, nevertheless it may be useful from time to time to attempt an appraisal of where we stand. In recent years we have had two collaborative attempts at such an appraisal. The American Association for the Advancement of Science held a symposium on "Mental Health" at its Richmond meeting in 1938.⁶⁰ A more penetrating evaluation of psychiatric research was offered a decade ago in *The Problem of Mental Disorder*, edited by Bentley and Cowdry as a committee of the National Research Council.⁶¹

In Bentley and Cowdry's survey an interesting and suggestive technique was used: skilled psychiatrists and teachers of psychiatry wrote essays on their activities and ideas, and skilled technologists attempted to sketch potential applications of technique. The results did not mesh very well with each other, in this instance, but the plan of attack seems sound. Practical work with patients and the scrutiny of what works well in practice (also what works not so well and what works badly) may suggest principles. The human being engaged in professional psychiatric work is himself a potential instrument of behavioral discovery, so to speak. Growth in skill and wisdom implies something like knowledge of an implicit sort, from which thoughtful consideration may evolve ex-

⁵⁹ Burrow, *The Biology of Human Conflict* (New York, Macmillan, 1937).

⁶⁰ *Mental Health* (Lancaster, Pa., The Science Press, 1939).

⁶¹ New York and London, McGraw Hill, 1934.

plicit questions, and explicit questions determine points for the infiltration and advance of scientific method. To cultivate individual skill in psychotherapy is of much value—for a limited circle of beneficiaries and for one generation. To cultivate skills in psychotherapy, for their yield of communicable insight, may multiply this value prodigiously in space and time.

Research can then be viewed roughly as of two types: that which elucidates the field for attack, and that which builds up support from the bases. The increasing maturity of scientific disciplines and disciples has softened somewhat the former contempt expressed by technical impresarios for the “catch as catch can” approach of the clinical psychiatrist in dealing with human nature awry; clinical psychiatrists have gained both assurance and humility and need not now, for scientific self-respect, recite the organicist or fundamentalist shibboleths of an adolescent scientificism. We have lost a bit of the shrillness of dispute and have gained a bit more of the poise of mutual respect. Microscope and test tube, biography and interview—these may be more fully used as tools, now that they are less used as disputatious weapons.

Laying aside ultimates, we have made some advance toward a practical understanding of human nature and toward formulations of personal issues which are useful in helping persons to find, develop, and maintain attitudes which make living for them more tolerable, secure, and zestful. The author, therefore, anticipates greater significant research progress in the next quarter century through the gradual development of more adequate insight into and knowledge of personal issues rather than through revolutionary discoveries, “molar” or “molecular.”⁶² Nevertheless, in combination with an increasing use of refined clinical and instrumental observation and biological experiment, this should logically proceed toward the more controllable and assured study of conditions which limit or disturb personal functioning, and toward the accelerated development of a sound and rational basis for the amelioration of such limiting or disturbing conditions.

⁶² See note 19, above.



AMARIAH BRIGHAM

HENRY ALDEN BUNKER
AMERICAN PSYCHIATRIC LITERATURE
DURING THE
PAST ONE HUNDRED YEARS

Felix qui potuit rerum cognoscere causas

IN THE *American Journal of Insanity* of October, 1851, there appears a notation which, however peripheral to American psychiatric literature of the past one hundred years, forms nevertheless a certain link—one as fateful as you like—between the earlier years of that centennium and the period in which these lines are written. This notation, reprinted by the *Journal* from the *Athenaeum* of March 23, 1850, runs as follows:

In Berlin, a curious subject for a thesis has been found by a student in medicine, the son of M. Groddeck, the deputy, seeking his degree. M. Groddeck has discovered a new form of epidemic, whose virus has of late circulated throughout the continental nations with a rapidity contrasting strongly with the solemn and stately march of cholera. Its development, indeed, has been all but simultaneous in the great European capitals, but we know not that it has before occurred to any one to treat it medically. M. Groddeck's thesis, publicly maintained, is entitled *De Morbo democratico, nova insaniae forma*.¹

The one hundred years of American psychiatric literature which the present chapter is to discuss takes its beginning with the publication of the first issue of the *American Journal of Insanity* in July, 1844. Thus the *Journal* is some three months older than the Association of Medical Superintendents of American Institutions for the Insane, formed when the Original Thirteen met in Philadelphia in October, 1844, at the suggestion of Dr. Samuel B. Woodward. If it was Dr. Woodward who pro-

¹ Another statement acquiring some added interest in the light of recent history, although equally irrelevant to the immediate theme of this chapter, appears in the 1867 volume of the *American Journal of Insanity*, in T. B. Belgrave's "The Asylums for the Insane in St. Petersburg and Copenhagen," reprinted from the *Journal of Mental Science* of April, 1867: "A conviction pervades the Danish nation that it is doomed to absorption by Germany; and this feeling has induced a settled melancholy, which the universal well-being of the people and the excellence of their Government only contribute to make more conspicuous. In social intercourse the destiny of the nation is constantly discussed and lamented. One result of this painful feeling is an increase in the proportion of lunatics to the general population. The predominating form of mental disease is melancholia, characterized in the majority of instances by a distressingly strong tendency to suicide."

posed (not without misgivings, it is said, as to the result)³ the first meeting of the Association, it was Dr. Amariah Brigham (1798–1849), first Superintendent of the State Lunatic Asylum at Utica, New York, who founded the *American Journal of Insanity*, “the result of his sole thought, and sustained, at first, by his own means, and in a considerable degree by his own pen,”⁴ although his name does not appear upon its title page, which reads only: Edited by the Medical Officers of the New York State Lunatic Asylum.

The *American Journal of Insanity* was the first periodical in the English language to be devoted exclusively to what was usually (if not altogether accurately) called psychological medicine, to “the doctrines and treatment of mental disorders.” This fact is the more remarkable in view of the honorable position which English “psychological medicine” had at that time occupied for a generation, in respect of institutional psychiatry, of efforts at medico-legal reform, and of medical psychology. And indeed, the (English) *Medico-Chirurgical Review* was moved to comment upon the advent of the *American Journal of Insanity* in words which are almost envious:

Brother Jonathan is, assuredly, going ahead in physic as well as in commerce and all the various branches of art, science and literature. . . . The Journal of Insanity conveys a new idea; and the wonder is that it never struck the encephalon of John Bull, who is not a little prone to this terrible malady, and who expends many millions annually on institutions for its reception and treatment.⁴

It was not until a number of years had passed, in fact, that John Bull was to follow suit in this particular respect—with the *Journal of Psychological Medicine and Mental Pathology*, founded by Forbes Winslow in 1848, and the *Journal of Mental Science*, in 1853. The literary trail blazed by the *American Journal of Insanity* was followed on this side of the Atlantic, during the succeeding thirty years until 1874, only by the *American Psychological Journal*, devoted chiefly, its title page reads, “to the elucidation of Mental Pathology, and the Medical Jurisprudence of Insanity,” founded in Cincinnati by Edward Mead, in 1853 (it survived but six issues), and by the *Quarterly Journal of Psychological Medicine and*

³ *Am. J. Insanity*, XXVII (1870–71), 139

⁴ *Ibid.*, XIV (1857–58), 1.

⁴ *Ibid.*, XXVI (1869–70), 410, footnote.

Medical Jurisprudence, founded in New York by William A. Hammond, in 1867.⁵

What was the situation, in this year 1844, with regard to psychiatric literature other than that in periodical form? We shall notice at once that American psychiatry lacks, although only in a relative sense, it is fair to say, the English-speaking priority which the founding of the *American Journal of Insanity* conferred upon it in the periodical field. In 1835, for example, J. C. Prichard had published in London *A Treatise on Insanity and Other Disorders Affecting the Mind*; in this he introduced the term "moral insanity" to denote a form of "madness consisting in a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions and natural impulses, without any remarkable defect in the intellect or knowing and reasoning faculties and particularly without any insane illusion or hallucination."⁶ This was a term and a conception the controversy concerning which was to fill many pages of American psychiatric literature as "the great *quaestio vexata* of psychological medicine" (as Pliny Earle called it),⁷ and of which no less a figure than Isaac Ray remained a staunch supporter. There followed

⁵ Despite its unique position in the English-speaking world, the *American Journal of Insanity* was not, of course, first in the field of psychiatric periodic literature. In the year preceding its founding, 1843, the *Annales Médico-psychologiques* had been founded in Paris. But true priority in the field must be given to Germany, for it is to Johann Christian Reil (of the "island of Reil") that must be given the honor of establishing in 1805, at Halle, the first periodical devoted solely to "the doctrines and treatment of mental disorders," the *Magazin für psychische Heilkunde*. This short-lived publication was followed in 1818 by Nasse's almost equally short-lived *Zeitschrift für psychische Aerzte, mit besonderer Berücksichtigung des Magnetismus*, in 1829 by Friedreich's *Magazin für die philosophische, medizinische und gerichtliche Seelenkunde*, which in 1833 became the *Archiv für Psychologie für Aerzte und Juristen*; in 1837 by *Blätter für Psychiatrie*; and in 1838 by the *Zeitschrift für die Beurteilung und Heilung krankhafter Seelenzustände*. To this not very lengthy catalogue of (non-English language) psychiatric periodicals which preceded the *American Journal of Insanity* should be added the Belgian *Annales Médico-légales*, founded in 1842, and, of the same date as the founding of the American publication, 1844, Damerow's *Allgemeine Zeitschrift für Psychiatrie*. It is a catalogue which would seem to bear out, in itself, Zilboorg's assertion that "Toward the close of the third decade and the beginning of the fourth [of the nineteenth century], the needs and security of medical psychology became crystallized, and psychiatry entered the field as a self-conscious, energetic branch of scientific medical discipline." Gregory Zilboorg, *A History of Medical Psychology* (New York, Norton, 1941), p. 383; see also Dr Sigerist's chapter, "Psychiatry in Europe at the Middle of the Nineteenth Century."

For an interesting review of early psychiatric periodical literature, see M. K. Amdur, "The Dawn of Psychiatric Journalism," *Am. J. Psychiatry*, C (1943-44), 205.

⁶ Zilboorg, *op. cit.*, p. 417.

⁷ *Am. J. Insanity*, XXIV (1867-68), 275.

in 1837 Benjamin C. Brodie's *Lectures Illustrative of Certain Nervous Affections*, one of the earliest contributions in the particular field of the psychoneuroses, in which the French and the English were to become the pioneers. In 1838 was published, in Paris, Esquirol's *Des maladies mentales, considérées sous les rapports médicaux, hygiéniques et médico-légals*. In 1843 there appeared a work entitled *Neurhypnology, or the Rationale of Nervous Sleep*, by the English surgeon, James Braid—a work of very considerable importance in its contribution to the ultimate birth of psychotherapy, and indeed of psychopathology as an independent study existing in its own right. Perhaps to this enumeration of some of the more representative volumes on psychiatric subjects which saw the light in the years immediately preceding the founding of the *American Journal of Insanity* might be added a statement made in 1844 by Thomas Laycock (whose *A Treatise on the Nervous Diseases of Women* had appeared in 1840): "Insanity and dreaming present the best field for investigating the laws of that extension of action from one portion of the brain to the other, by which ideas follow each other in sequence."⁸

With one major and three minor exceptions immediately to be noted, only one work of American origin can be numbered among the more outstanding volumes on psychiatric subjects which were in existence in 1844—but a work which, in its own field, took and long maintained a leading place: Isaac Ray's *A Treatise on the Medical Jurisprudence of Insanity*, published in Boston in 1838. On the one hand, this was the first systematic work in the field of psychiatry from the pen of an American author since Benjamin Rush's textbook, *Medical Inquiries and Observations upon the Diseases of the Mind* (1812), and on the other, the most original and comprehensive work on the medical jurisprudence of insanity, at the time of its publication, in the English language. It was a work of which it was thought not too much to say, on the occasion of the appearance of a fifth edition in 1871, that directly and indirectly it had done more than all others "to shape our laws, and the decisions of

⁸ This statement becomes more intelligible in a later amplification in which, writing of a patient at York Retreat, "whose will being suspended, he expressed ideas as they spontaneously arose in associated sequence, the combination being singularly varied, but traceable to a common root or center of impulse," Laycock says that "Researches of this kind, whether instituted on the insane, the somnambulist, the dreamer or the delirious, must be considered like researches in analytical chemistry." Quoted from Daniel Hack Tuke, *Chapters in the History of the Insane in the British Isles* (London, Kegan Paul, 1882), p. 469.

our courts, in regard to the insane."⁹ Thus it was a pioneer work of American psychiatry to at least the same degree as the textbook of Benjamin Rush. To these two full-dress works of 1812 and 1838 (each of which reached a fifth edition—in 1835 and 1871, respectively) should be added three lesser volumes which had appeared by the time (1844) our present chronicle of American psychiatric literature begins: Amariah Brigham's *Remarks on the Influence of Mental Cultivation and Mental Excitement upon Health* (1832), Thomas C. Upham's *Outlines of Imperfect and Disordered Mental Action* (1840), and William Sweetser's *Mental Hygiene* (1843). These three works, for all their modesty in comparison with the treatises of Benjamin Rush and Isaac Ray, nevertheless are distinguished for their expressions of an idea which long remained in eclipse: the idea (in the words of Upham) that insanity, far from having physical disorder exclusively as its basis, may have causes "more remote from common observation, . . . more intimately connected with the mind's interior nature and secret impulses."

In so far as the annual reports of the superintendents of mental hospitals form a not unimportant part of American psychiatric literature, it should perhaps be mentioned that it seems to have been to some extent characteristic of this same period to entertain a rather undue optimism with regard to the curability of "insanity." At all events, we find several such reports, between the years 1835 and 1843, in which a recovery rate of eighty to one hundred per cent is claimed for cases of less than one year's duration. Or, in the summarizing words of Samuel B. Woodward, founder of the Association of Medical Superintendents, and Superintendent of Massachusetts's first State Hospital for the Insane, at Worcester: "In recent cases of insanity, under judicious treatment, as large a proportion of recoveries will take place as from any other disease of equal severity"; and again, eight years later, in 1843: "I think it not too much to assume that insanity, unconnected with such complications as epilepsy, paralysis, or general prostration of health, is more curable than any other disease of equal severity; more likely to be cured than intermittent fever,

⁹ *Q. J. of Psychological Med.*, VI (1872), 106. Isaac Ray, in turn, called Benjamin Rush's volume "the first of the kind in the English tongue displaying thorough observation and original thought." Quoted by Cowles, *Am. J. Insanity*, LI (1894-95), 14.

For Benjamin Rush, see for example Frank Woodbury, "Benjamin Rush, Patriot, Physician, and Psychiatrist, a Centennial Memorial Note," *Am. J. Insanity*, LXX (1913-14), 941, and, more recently, Nathan G. Goodman's *Benjamin Rush: Physician and Citizen* (Philadelphia, Univ. of Pennsylvania Press, 1934).

pneumonia, or rheumatism." On the other hand, a comparison more valid than that with "other disease of equal severity," and certainly more conservative, was drawn by Isaac Ray in his assertion, in his report for the year 1844, that "he would be a bold man who should venture to say that Pinel and Esquirol, whose medical treatment was confined chiefly to baths and simple bitter drinks, were less successful in their cure of mental diseases than those numerous practitioners who have exhausted upon them all the resources of the healing art."¹⁰

Such, then, in mere outline, was the background of psychiatric literature against which the *American Journal of Insanity* made its entry in 1844, a background characterized predominantly by an intensive interest in the care of the mentally ill and the organization and administration of mental hospitals, and in forensic psychiatry and legislative reform as this affected the "insane." Alongside a rather less conspicuous interest in the nature of mental disease, the beginnings of psychological interpretation were being manifested (Bertrand in France, Brodie and Braid in England), even though these beginnings, then and for many years thereafter, in America no less than elsewhere, met with almost complete disregard.

Thus, much of American psychiatric literature, as represented in the first twenty-five years of publication of the *American Journal of Insanity*, was necessarily concerned with the plans and description of the various mental hospitals erected during that period, with historical and descriptive accounts of certain of those already in existence, and with the general subject of the construction, organization, and general arrangements of hospitals for the insane and of the administrative problems arising in connection with them. As Pliny Earle wrote in 1868, "Of all the subjects legitimately belonging to the specialty of psychiatry, or immediately connected with it, no one has, for the last few years, occupied a more prominent position in the United States, or called forth a larger number of words, oral, written and printed, than the proper provision for the custody, care and cure of the insane."¹¹

As early as 1854, Thomas S. Kirkbride (1809-1883) published a small volume of eighty pages, with the title I have used above, *On the Construction, Organization and General Arrangements of Hospitals for the In-*

¹⁰ Pliny Earle, "The Curability of Insanity," *Am. J. Insanity*, XXXIII (1876-77), 483. Isaac Ray, "Recoveries from Mental Disease," *ibid.*, XXXVI (1879-80), 250. For a fuller discussion of the "curability myth," see Albert Deutsch's chapter on "The History of Mental Hygiene."

¹¹ "Prospective Provision for the Insane," *ibid.*, XXV (1868-69), 51.

sane; the second edition, appearing in 1880, contained over 300 pages. In the words of Zilboorg,

In the United States the physician interested in the mentally ill devoted himself almost exclusively to hospital administration, to an almost devotional training and organization of appropriate staffs of attendants, and to the creation of a unique type of mental hospital medical superintendent—a man humane and learned, who was to be physician and guide, master and assiduous pupil. In the course of the century the theory and practice of American psychiatry was the theory and practice of institutional psychiatry, which culminated in a unique achievement¹³

These words cap those of Pliny Earle in underscoring the sphere in which, in these earlier years, American psychiatry and American psychiatric literature manifested an originality and an energy less present, as we have already seen, in other fields of psychiatric endeavor.

One aspect of the care of mental patients which gave rise to considerable discussion, on the part of members of the Association and in the pages of the *American Journal of Insanity*, was that of the question of the use of mechanical restraint. Its total abolition had been ardently advocated by the English psychiatrist John Conolly as early as 1830, in *An Inquiry Concerning the Indications of Insanity; with Suggestions for the Better Protection and Cure of the Insane*, and again, and even more uncompromisingly if possible, in 1856, in his *Treatment of the Insane without Mechanical Restraints*. In the latter Conolly professed "the extremest jealousy of admitting the slightest occasional appliance of mechanical restraints in any asylum," for, he asserted, "once admitted, under whatever pretext, and every abuse will follow in time."¹⁴ The American attitude to this question was always somewhat less uncompromising than Conolly's. For example, at its first meeting in 1844 the Association of Medical Superintendents "by resolutions expressing its unanimous sense, declared its position manfully regarding a question which has perhaps provoked more animated and sometimes acrimonious controversy than any other connected with the management of the insane, holding as it did that the true interests of the insane forbade the abandonment of all means of personal restraint in their treatment."¹⁵ And in 1846, Isaac Ray

¹³ Zilboorg, *op. cit.*, p. 409.

¹⁴ Page 29. Quoted by W. Lauder Lindsay, "The Theory and Practice of Non-Restraint in the Treatment of the Insane," *Am J Insanity*, XXXV (1878-79), 272.

¹⁵ John H. Callender, "History and Work of the Association of Medical Superintendents of American Institutions for the Insane," *Am J Insanity*, XL (1883-84), 1.

—who, although, in Zilboorg's words, "one of the greatest and most humane personalities in psychiatry, disagreed with Conolly's premises and practices"¹⁵—wrote:

In those institutions where restraint is still practised it seldom exceeds one or two per cent, for weeks and months together it may not be used at all . . . I cannot help concluding that this question of restraint or non-restraint has received a degree of attention altogether disproportionate to its intrinsic merits. I do not mean to sanction the idea that the imposition of restraint is an unimportant matter. On the contrary, I would have it regarded as in most cases a necessary evil, used only for the prevention of a greater.¹⁶

Finally, although not altogether with finality, the discussion of this question occupied a considerable part of the twenty-eighth annual meeting of the Association of Medical Superintendents held in 1874—a discussion precipitated by Dr. Mark Ranney's paper on "An Act to Protect the Insane, with Special Reference to the Use of Mechanical Restraint . . .,"¹⁷ apropos of a class of cases "which, as has been said by Dr. Ray, 'must always prevent the existence among us of thoroughgoing advocates of non-restraint.'"¹⁸ The upshot of this discussion may be summarized in the words of Dr. Smith, Superintendent of the State Asylum, Missouri:

The question has been very freely discussed at previous meetings of this Association, and the result, almost entire uniformity of sentiment in all well-conducted American institutions for the insane. No restraint is the general rule, and restraint the exception; while for many years past the tendency in this country has evidently been to reach the point of least possible restraint, there have been very few, if any, converts to the non-restraint system in the true sense of the term.¹⁹

Nevertheless, Dr. Worthington, of the Friends Asylum, came very near to rebellion against the law of the majority when he asserted that "since the use of mechanical restraints has been almost entirely discontinued, there has been far less trouble in the management of the patients"; while Dr. Lett (of Canada) even went so far as to say that "I think there are very few cases where it is necessary to apply it. So far as my experience

¹⁵ Zilboorg, *op. cit.*, p. 415.

¹⁶ "Observations on the Principal Hospitals for the Insane, in Great Britain, France, and Germany," *Am J Insanity*, II (1845-46), 358.

¹⁷ Abstracted in *ibid.*, XXXI (1874-75), 159.

¹⁸ *Ibid.*, p. 164.

¹⁹ *Ibid.*, pp. 177-178.

goes, I think this is simply a question between good attendants and restraint."²⁰ Herein the latter sounded the keynote of a consequence of the nonrestraint campaign of no small significance, as Zilboorg has denoted it: "Since it enhanced the need for greater ingenuity in supervising and managing the mental patient, it naturally imposed the need for better training of the supervising personnel—the attendants and the orderlies. This was the added circumstance which later created special training schools for psychiatric nurses."²¹

A subject which called forth an even greater number of words, during the first three or four decades of American psychiatric literature, than "the proper provision for the custody, care and cure of the insane," was that of the law in relation to "insanity," of medical jurisprudence as applied to the "insane," of psychiatric medico-legal theory, of the vexed question of the "legal responsibility" of the "insane." Some reflection of the scope of this problem is apparent in the fact that "medical jurisprudence" stands alongside psychiatry itself in the title or subtitle of the two American periodicals, other than the *American Journal of Insanity*, established during this earlier period.²² During this period, moreover, there was hardly an issue of the *Journal* but contained an account of the court proceedings in a criminal case (most usually homicide) in which a plea of insanity had been entered, or a discussion of medico-legal principles in connection with these and similar cases "bearing upon insanity." In the first twenty-five volumes of the *American Journal of Insanity* some eighty such articles appeared, including translations from the French and the German. Early in this period—in 1850—it is not surprising to find a reply by Luther V. Bell to "those sneers at the plea of insanity in which respectable, and otherwise intelligent, men sometimes indulge"; to which

²⁰ *Ibid.*, p. 169. See also Bucknill, "Notes on Asylums for the Insane in America," *ibid.*, XXXIII (1876-77), 146.

²¹ Zilboorg, *op cit.*, p. 415. See also in *Am J Insanity*, XXIV (1877-78) Eugene Grissom, "Mechanical Protection for the Violent Insane" (p. 27), "Proceedings of the Association" (pp. 160 ff.), "Restraint in British and American Insane Asylums" (p. 512), XXXV (1878-79): W. Lauder Lindsay, "The Theory and Practice of Restraint in the Treatment of the Insane" (p. 272), "Mechanical Restraint in English Asylums" (p. 543), and A. M. Shaw, "Mechanical Restraint" (p. 556), XXXVI (1879-80) W. Lauder Lindsay, "Rib-Fracture in English Asylums" (p. 28) and "The Protection Bed and Its Uses" (p. 404).

For a recent historical survey of the subject, see E. Messinger and Meyer K. Amdur, "Abstract" of "One Hundred Years of Non-restraint," *Am. J. Psychiatry*, XCIV (1937-38), 1307.

²² I.e., *The American Psychological Journal, Devoted chiefly to the elucidation of Mental Pathology, and the Medical Jurisprudence of Insanity* (1853), and the *Quarterly Journal of Psychological Medicine and Medical Jurisprudence* (1867).

the Editor of the *Journal* adds that "if the frequency of this plea has grown into an evil, it would be more becoming to ascertain its causes and furnish a remedy by suitable legislation than to throw suspicion upon the honesty and intelligence of medical men who are called on for their opinions."²⁸ But twenty years later things were no different, to judge from an article²⁹ in which we find it roundly stated that:

There are no positions in which medical men are placed where they make so discreditable an exhibition as in trials where insanity is pleaded or attributed. This is chiefly the fault of the law, which is the same in the United States as in England and Canada, and which lays down the principle that a knowledge of right and wrong is the test of soundness or unsoundness of mind. And the state of mind of the criminal or defendant at the time of commission of the crime is left to the decision of twelve men of such ordinary intelligence as pertains to the average of common jurymen. And medical men are left to squabble over the puzzle whether the unfortunate subject knew right from wrong, a knowledge which, to judge from common observation, is as far from the powers of very many sane people as from the insane

This, of course, but echoes the asseveration of many others, among them, for example, John Ordronaux, Professor of Medical Jurisprudence at Columbia College, and later to become State Commissioner in Lunacy, who, writing of the history and philosophy of medical jurisprudence, called it the highest duty of the medical jurist to expound to courts "the utter fallacy of making the knowledge of right and wrong a test of sanity."³⁰ Well has Zilboorg remarked that "Criminology today, like demonology of yesterday, is a battlefield for the possession of which the psychiatrist is still fighting."³¹ Small wonder, then, that sixty years ago, in 1884, no less an authority than the great English psychiatrist, John Charles Bucknill, could write that "perhaps no medico-legal ques-

²⁸ *Am. J. Insanity*, VI (1849-50), 318

²⁹ Henry Landor, "Insanity in Relation to Law," *ibid.*, XXVIII (1871-72), 56.

³⁰ John Ordronaux, "History and Philosophy of Medical Jurisprudence," *Am. J. Insanity*, XXV (1868-69), 173. It was Ordronaux who, in a Report to the Legislature in 1874, brought attention to the necessity of revising and codifying the laws relating to the insane in the State of New York—laws which had never been codified, but "were scattered through the volumes of our legislative enactments from the very origin of our government." It was in obedience to a resolution of the Senate directing the Attorney General and Dr. Ordronaux to report to the Legislature a codification of the laws relating to the insane that an act was reported which "constitutes the present Code, known as Chapter 446, Laws of 1874."

³¹ *Op. cit.*, p. 419.

tion has been more discussed, and with fewer results, for the past forty years," than the question of the relation of "madness" to crime.²⁷

However few the results during the first forty years of the *Journal*, or during the succeeding sixty, there can be no doubt that among the *causes célèbres* of American jurisprudence, up to this time, must be ranked the trial, extending from November 16, 1881, to January 26, 1882, of Charles Julius Guiteau, who on July 2, 1881 had shot General James Abram Garfield—by a curious irony, probably our most reluctant President—some four months after his accession to office. At Guiteau's trial eight medical witnesses testified in favor of the insanity of the accused, fifteen physicians—including Allan McLane Hamilton, A. E. Macdonald, and John P. Gray—testified to having formed an opinion to the effect that the prisoner was sane and responsible before the law. Among the former, Dr. Walter Channing held it to be a delusion that Guiteau, "an insignificant good-for-nothing," believed himself "entitled to one of the most important offices in the gift of government." On the other hand, the admissions which the prisoner made during his examination by Dr. John P. Gray exposed the true nature of "the supposed delusion that the prisoner believed he was inspired to the act by the Deity"—for, as Bucknill comments, not only could no other belief at any time attributed to Guiteau be "reasonably construed into an insane delusion," but that the belief just referred to was not a delusion "is evident from the fact that it was derived from the teachings of others [namely, the Oneida Community]; that it was not the result of disease. It was a sane belief, probably as sincere as many other religious beliefs."²⁸ We must pass over the arresting fact (and the reflections to which it could lead) that the most eminent psychiatrist of his day should fall into error with regard to both delusion and religious belief simultaneously, the latter little less remarkably than the former, in order to refer in conclusion to the summing up of the Presiding Justice, of which it was said not only that it was a careful statement of the law of insanity in America "at the present time,"²⁹ but that "probably no cause heretofore tried in the courts of this country or

²⁷ "A Lecture on the Relation of Madness to Crime," *Am. J. Insanity*, XL (1883-84), 412 (reprinted from the *British Medical Journal*)

²⁸ Bucknill, "The Plea of Insanity in the Case of Charles Julius Guiteau," *Am J Insanity*, XXXIX (1882-83), 181 (reprinted from *Brain*, July, 1882).

²⁹ "Case of Guiteau," *Am. J. Insanity*, XXXIX (1882-83), 199 (reprinted from the *J. Mental Sci*, July, 1882).

of Europe can show a more patient, thorough and satisfactory elaboration of the true principles of medical jurisprudence as applied to the question of insanity when pleaded as a legitimate defense for crime."⁸⁰

Turning to the legal status of the insane, we find that as early as 1850, at the fifth meeting of the Association of Medical Superintendents of American Institutions for the Insane, Isaac Ray invited the attention of that body to the state of the law as it affected the civil rights, condition, and interests of the insane, and to the necessity of its modification into harmony with "the generally accepted doctrines of medical science."⁸¹ Thirteen years later, in 1863, a committee composed of a member from each state was appointed to frame the project of a general law after thorough examination of the deficiencies held to be present in the then existing statutes in the various states; and in 1868, the Association went on record in the matter in the following words:

The Association of Medical Superintendents of American Institutions for the Insane, believing that certain relations of the insane should be regulated by statutory enactments calculated to secure their rights and also the rights of those intrusted with their care, or connected with them by ties of relation, or friendship, as well as to promote the ends of justice, and enforce the claims of an enlightened humanity, for this purpose recommend that the following legal provisions be adopted by every State whose existing laws do not, already, satisfactorily provide for these great ends.⁸²

There follow the twenty-one provisions of the "Project of a Law" defining the legal status of the insane—surely to be reckoned one of the

⁸⁰ *Ibid.*, p. 208. The 1881-82 volume of the *American Journal of Insanity*, which contains Dr. John P. Gray's 146-page summary of "The Guiteau Trial," also contains, as it happens, several other examples of what the psychoanalyst would necessarily call the "murder of the father." The opening article of the issue of January, 1882, is entitled "On the Mental Condition of Giovanni Passanante—(Attempted Regicide)," translated from the *Rivista Sperimentale di Freniatria di Medicina Legale*, and dealing with the attempted assassination of King Humbert, of Italy, on November 17, 1878 (page 273). We also find the "Trial and Execution of Bellingham, for the Murder of Mr. Perceval, Prime Minister of Great Britain." This murder took place on May 11, 1812, the reprinting was stimulated by the frequent allusions to the case which occurred during the trial of Guiteau (page 449). And finally we have the account of a murderous assault upon Dr. John P. Gray committed "by a citizen of Utica, named Henry Remshaw," fortunately without fatal result (page 466), not so fortunate was the first assistant physician at the State Hospital for the Insane, Kalamazoo, Michigan, who was fatally stabbed by a patient in that institution on January 6, 1882 (page 468).

⁸¹ *Am. J. Insanity*, VII (1850-51), 215; XL (1883-84), 1.

⁸² *Q. J. Psychological Med. and Med. Jurisp.*, III (1869), 495. Here will be found reprinted in full the twenty-one provisions of the "Project of a Law." In this general connection, see also Dr. Zilboorg's chapter, "Legal Aspects of Psychiatry."

early milestones of American psychiatric literature. The provisions were finally adopted unanimously and *in toto* (although not without such differences of opinion that it was seriously proposed that the subject be dropped entirely), not as intended for general adoption by all the States, but "as expressing the sentiment of the Association regarding what would be a proper law for States in which no law at present exists on the subject, or for States in which existing laws are insufficient, or not in accordance with the present status of mental science."⁸

The third major topic with which earlier American psychiatric literature was concerned—but if "third" in respect of the number of pages devoted to it in the *American Journal of Insanity* and elsewhere, this position underwent a certain revision upward in later years—is that of the etiology of "insanity," that of the nature and causation of mental disorder. Here in America the orientation was, even more exclusively perhaps than in England and Europe, an anatomico-pathological one—an orientation which was the product of what Gruhle called "brain mythology," the expression of what Zilboorg has termed a "psychiatry without psychology." Of this predominating school of thought the chief spokesman was John P. Gray, who, as its second editor-in-chief, presided over the fortunes of the *Journal* for thirty-two years, from 1854 until his death in 1886. Few, on the whole, were the voices raised in dissent from his assumption of a physical (cerebral and/or extra-cerebral) origin and causation of mental disorder, an assumption to which in particular Wilhelm Griesinger (1817–1868) in Germany, and Henry Maudsley (1835–1918) in England, among others, lent the weight of their authority. Yet among these few voices was that of Amariah Brigham, founder and first editor of the *Journal*, and also originator of the tables of statistics of causation at the Utica Asylum. Brigham "held, with Pinel, Esquirol, and Georget, that moral [i.e., emotional] causes were far more operative than physical in the production of insanity."⁹ In similar vein wrote Jarvis in 1851: "The moral causes are, according to the record, almost as abundant as, and probably they really are more abundant than, the physical causes."¹⁰ A third example among the very few who during the first fifty years of American psychiatry opposed the "physical-basis theory" of insanity was H. B. Wilbur, whose article on "Materialism in Its Re-

⁸ *Ibid.*, p. 505

⁹ H. B. Wilbur, "Materialism in Its Relation to the Causes, Conditions and Treatment of Insanity," *Q. J. Psychol. Med.*, VI (1872), 29

¹⁰ Edward Jarvis, "On the Supposed Increase of Insanity," *Am. J. Insanity*, VIII (1851–52), 331

lation to the Causes, Conditions and Treatment of Insanity," just quoted, was largely a counterblast to John P. Gray's "The Dependence of Insanity on Physical Disease."⁸⁶ On these two articles the *Journal*, under the caption "Is Insanity a Disease of the Mind, or of the Body?"⁸⁷, made the comment:

The papers here cited present two opposite views held by pathologists as to the nature, causes and treatment of insanity. On the one hand it is held to be a disease of the brain, originating in that organ or in other parts of the body, depending on physical causes, or on moral causes only so far as they are capable of producing physical effects, and to be treated by the same methods as other bodily diseases. On the other hand it is held to be a disease of the immaterial mind, depending for the most part directly on moral causes, and to be treated by moral agencies. •

—a statement, as clear as it is succinct, of the antinomy in question, as it is also of a point of view which, despite its limitations in respect of what were taken to be "moral" or emotional causes, was nearly fifty years ahead of its time. What, on the other hand, were the trenchant if somewhat Delphic words of the great physiologist Claude Bernard upon this antinomy? —words which are a part of American psychiatric literature, since the *Journal* published a translation from the *Revue des Deux Mondes* of his article entitled "Physiology: the Functions of the Brain."⁸⁸ "Some will not admit," he wrote, "that the brain is the organ of intelligence, just as the heart is the organ of circulation, because they fear to be involved in materialistic doctrines; while others, on the contrary, hasten to place the intelligence in a round or fusiform nerve-cellule, so as not to be taxed with spiritualism."

No cerebral pathology, no "insanity": this was the tenet of the anatomico-pathological, or somatic, school of thought, of the adherents of the "physical-basis theory" of mental disorder, which thus was considered to be invariably dependent upon brain disease for its origin and nature. This was considered true at least for its immediate origin; for it was equally the belief that "insanity" more frequently had its primary origin in pathological states outside of the brain than in primary diseases of the brain, although the "insanity" is not manifested until the brain is actually involved. In 1870, the *American Journal of Insanity*

⁸⁶ *Am J Insanity*, XXVII (1870-71), 377.

⁸⁷ *Ibid.*, XXIX (1872-73), 71.

⁸⁸ *Ibid.*, p. 21.

expressed itself editorially—and thus presumably in the words of John P. Gray—quite explicitly upon this point:

Though it [insanity] is a cerebral disease, the primary pathologic cause in the majority of cases is not to be looked for in the brain. Perhaps no other cerebral disorder is dependent on so wide a range of extra-cranial initiative pathologic causation as insanity. And while it is a necessary proposition that insanity is always a disease of the brain, without regard to original causation, it is probably also a fact that until the anterior lobes or their membranes are involved, extensive cerebral disease may exist without producing insanity³⁹

This certitude appears somewhat inconsistent with the dissatisfaction with the state of psychiatric knowledge at the beginning of the last quarter of the nineteenth century, which an earlier passage in the same editorial seems to convey:

What Bichat said half a century ago [in 1818] of *Materia Medica* might almost be said of Psychological Medicine today, as far as the general medical profession is concerned. It is "an incoherent assemblage of incoherent opinions; it is perhaps of all the sciences the one which shows most plainly the contradictions and wanderings of the human mind—a shapeless conglomerate of inexact ideas, of observations often puerile, and of illusory remedies."

Gray had already said, two years before, that, while in urging the greater importance of somatic symptoms he would not wish to be understood as ignoring the value of psychological manifestations, "to diagnose the nature and seat of the physical lesion of the brain and nerves is the great problem to be solved in each individual case."⁴⁰ And in similar vein we find him, three years later, decreeing that

It is for us to inquire, therefore, (1) Whether there are specific changes in the brain in insanity, and if so, whether there are any means of ascertaining positively or proximately what those changes are. (2) Are there physical signs and symptoms indicating the presence and progress of such changes, which may be detected and relied upon, and what these are? (3) Are there post-mortem appearances in the brains of those who die insane, which would justify the assumption that morbid cerebral changes were the potential and only ultimate causation of insanity? (4) Are there any sound reasons for an assumption that the mind can overthrow itself, independent of cerebral changes? . . . What are denominated mental symptoms have a subordinate place in diagnosis as well as in treatment. The mental manifestations, indeed, have the same relation to diagnosis and treatment that mental phenomena

³⁹ "Clinical Teaching and Pathological Investigations on Insanity," *ibid*, XXVI (1869-70), 408

⁴⁰ John P. Gray, "Insanity, and Its Relations to Medicine," *ibid*, XXV (1868-69), 145.

hold in delirium tremens, fevers, and diseases of children. They are symptoms, but only significant of conditions of the nervous system, which *conditions* are to be treated. In all the disorders of the brain, we mark carefully what symptoms or groups of symptoms given cases manifest, and by this clinical observation, and by a knowledge of physiological laws, and by post-mortem examinations, we learn to interpret the morbid changes going on within the skull. There are no reasons why insanity should prove an exception to this rule.⁴¹

It is in words not very different from these that Blandford wrote in the preface to his *Insanity and Its Treatment*, published (in Edinburgh and Philadelphia) in the same year: "I am convinced that the only method by which we shall attain an insight into the mysterious phenomena of unsound mind is to keep ever before us the fact that disorder of the mind means disorder of the brain, and that the latter is an organ liable to disease and disturbance, like other organs of the body, to be investigated by the same methods, and subject to the same laws"—"a position," the reviewer of this volume adds, "held for years by this *Journal*."⁴²

In concluding this summary statement of a conception which dominated American psychiatry (and psychiatry abroad) for many years, it is necessary to quote Gray's words once more. Speaking before the New York State Medical Society in February, 1872, he said that he fully believed "what Maudsley is 'tempted sometimes to think,' that insanity occurs only as the result of physical causation—that a necessary antecedent to madness is a disordered physical state of the brain—that it never occurs in a person of sound brain." Even though Dr. Brigham had declared it as his opinion that moral causes predominated in the development of insanity, he had "nevertheless qualified this declaration in the following words: 'It is true that moral and mental causes may produce insanity, but they produce it by first occasioning either functional or organic disease of the brain. On examining the heads of those who die insane, some disease of the brain or its appendages is generally found.' " Thus of grief and of jealousy, and thus of "excitement in business or politics or religion," Gray said, "these are in one sense moral causes, but as moral influences alone, they are insufficient to produce insanity; as remarked by Dr. Brigham, they must *first* induce physical disease." "Even in those cases in which Griesinger speaks of moral causation, or the di-

⁴¹ Gray, "The Dependence of Insanity on Physical Disease," *ibid.*, XXVII (1870-71), 406.

⁴² *Am. J. Insanity*, XXVIII (1871-72), 78

rect influence of emotion, he admits the doctrine of a physical pathological change as the only adequate causation, for it is only when the disturbances of the circulation or other influences induce 'intense irritation of the brain,' 'and this irritation continues,' that insanity results." In a word, then, said Gray, "The exciting causes of insanity, as far as we are able to determine, are physical; that is, no moral or intellectual operations of the mind induce insanity apart from physical lesion."⁴³

In the following year, Dr. Gray made an initial report on "special microscopic work" upon which his staff had been engaged for several years.⁴⁴ To him an arresting fact was "the similarity of histological changes attending the different forms of insanity"—explicitly including, it would appear, general paresis. If future investigations yielded this same result, it would confirm, Gray said, "the principle that, in insanity, we have to contend with only one disease, manifesting itself under different phases in its progress and results." But even the cases thus far examined "go to strengthen the conviction . . . that insanity is a physical disease of the brain, and that the mental phenomena are symptoms."

But, like Esquirol, Isaac Ray was less certain on this point. At the twenty-seventh annual meeting of the Association of Medical Superintendents, held in 1873,⁴⁵ he stated that the pathological anatomy of the brain had thus far furnished "no grounds whatever for a rational theory of insanity." On the contrary, despite the minute description of the morbid changes in every form of insanity, "we have gradually been coming to the conclusion that they have but little to do with the disease, being in fact only the sequel of the disease or something else that has gone before. I think," he added, "that Esquirol doubted if the brain was the seat of insanity." The results of microscopical observations "have been more remarkable for discrepancy than agreement." One cannot but recall the words—although they do not belong to the *corpus* of American psychiatric literature—in which, not many years later, Hack Tuke described the visit which he paid in the early eighteen fifties to Schroeder van der Kolk, whom he found full of enthusiasm in the midst of his microscopical sections. "And this enthusiasm," remarks Tuke rather drily, "I cannot but suspect insensibly colored what he saw in the brains and cords of the insane, or he would hardly have said, as he did say, that

⁴³ Gray, "Thoughts on the Causation of Insanity," *ibid.*, XXIX (1872-73), 275.

⁴⁴ Gray, "Pathology of Insanity," *ibid.*, XXX (1873-74), 305.

⁴⁵ *Am. J. Insanity*, XXX (1873-74), 185-186

he had never failed during a quarter of a century to find a satisfactory explanation after death of the morbid mental phenomena during life."⁴⁶

Not altogether without pertinence in this connection, perhaps, are the words in which Tuke, speaking in the same chapter of the pioneer work of Elliotson on induced hallucinations and delusions, published in 1838, and of similar observations by himself in 1866, writes of the conclusion as being forced upon us "that there may be cases in which no change takes place in the brain which the ablest microscopist is likely to detect, but a dynamic change"⁴⁷—a change which involved, in Tuke's conception, loss or excess of "inhibition."⁴⁸ The view that "insanity" might occur without gross or even microscopic change in the brain as "a precedent fact and cause" thereof was, of course, no more shared by the majority of Tuke's compatriots than it was in this country, indeed, we find Winslow, editor of the *Journal of Mental Science*, saying. "Can we conceive a more preposterous notion than that sanctioned by high authority, which inculcates that the spiritual principle admits of being distorted, deluded, depressed, exaggerated, perverted, exalted, independently of any bodily disease or modification of nervous matter?"⁴⁹ And in France, Auguste Voisin's *Leçons cliniques sur les maladies mentales professées à la Salpêtrière*, published in 1876, was hailed by the *American Journal of Insanity* as the "first concise and earnest attempt in France to give to the anatomico-physiological theory of mental diseases its deserved and prominent place."⁵⁰ As for Germany, we find a somewhat extended notice given in the 1882 volume of the *Journal* to Flechsig's *Die körperlichen Grundlagen der Geistesstörungen: ein Vortrag* (A Lecture on the Physical Basis of Insanity), the author's inaugural lecture on the occasion of his accession to the newly established Chair of Psychiatry in the University of Leipzig,⁵¹ in which he "places himself exclusively upon the solid basis which regards insanity as a symptom of brain disease, or, in other words, mental derangement as an evidence of disease of the organ of

⁴⁶ Tuke, *op. cit.*, p. 478.

⁴⁷ *Ibid.*, p. 473

⁴⁸ See Zilboorg (*op. cit.*, p. 418). "To him [Tuke] man functioned by virtue of certain inhibitions (social and moral), and it was improper functioning of these inhibitions that Tuke designated as 'inhibitory insanity'—a trend of thought and a concept fully in harmony with our present-day views on psychopathological reactions, particularly those involving criminal behavior."

⁴⁹ Quoted by Gray, "General View of Insanity," *Am. J. Insanity*, XXXI (1874-75), 443

⁵⁰ *Am. J. Insanity*, XXXII (1875-76), 523

⁵¹ *Ibid.*, XXXIX (1882-83), 89.

mind." And here, indeed, is one of those coincidences, if such they should be called, which give a fillip to the sometimes jaded palate of the historian. For it fell to the lot of Flechsig, himself an exponent of the physical-basis theory of mental disorder, as just enunciated, to stand as a kind of connecting link between the older "so-called psychical school" of psychiatry and the newer. On the one hand, that is to say, Flechsig succeeded to a professorship which had had an ephemeral existence in the beginning of the nineteenth century, when the famous Heinroth lectured, we are told, with great *éclat*—Johann Christian Heinroth (1773–1843), who was able to say that "madness is a disease of the entire being," who thought of mental health as "nothing more than harmony of thought and desire" and disease, conversely, as "nothing but the result of a loss of this blessed unity of action," "a diathesis without which external actions could not create insanity," who thus groped his way toward a psychology of what we should now call the superego and the sense of guilt, and who, "precisely because his doctrines are at total variance with modern opinion, interests us as the most accomplished representative of a race of powerful minds, which is today almost extinct."⁵² On the other hand, it so happened that Flechsig—entirely fortuitously, to be sure—was at one time the physician (and also the "persecutor") of Dr. Jur. Daniel Paul Schreber, whose *Denkwürdigkeiten eines Nervenkranken* (*Memoirs of a Neurotic*) became the instrument, at the hands of Freud, of the first application—apart from the partial exception of his *Der Wahn und die Träume in W. Jensens "Gradiva"* (1907)—of psychoanalytic principles to psychosis and psychotic phenomena.⁵³

To return to American psychiatric literature. It was in 1869 that Dr. George M. Beard, of New York, undertook to describe a condition of the nervous system to which he applied the term "neurasthenia," while at the same time disclaiming originality in this description except with regard to the term itself. As he expressed it in this earliest article of 1869,

⁵² Benjamin Ball, "A Retrospect of Mental Medicine," *ibid*, XXXVII (1880–81), 73. Translated from the *Annales Médico-psychologiques*, January, 1880. Cf. also Zilboorg, *op. cit.*, pp. 470–471, and Bertram D. Lewin, "Zur Geschichte der Gewissenspsychologie," *Imago*, XIV (1928), 441 (also cited by Zilboorg, *op. cit.*, p. 471).

⁵³ Freud, "Psychoanalytische Bemerkungen über einen autobiographisch beschriebenen Fall von Paranoia (Dementia paranoides)," *Jahrb. f. Psychoanalyse*, III (1911), 9. Freud had also, as early as 1896, discussed "chronic paranoia" from this standpoint, in "Further Remarks on the Defense Neuro-Psychoses," *Collected Papers* (London, International Psychoanalytical Press, 1924), I, 169–182.

"The morbid condition or state expressed by the term has long been recognized and to a certain degree understood, but the special name *neurasthenia* is now for the first time presented to the profession."⁵⁴

What was the morbid condition or state which Beard considered to be a definite clinical syndrome, which he termed neurasthenia or nervous exhaustion, and which he later called the most frequent, most interesting, and most neglected nervous disease of modern times, and "the center and type of this family of functional nervous diseases?"⁵⁵ According to his earliest formulation, "If a patient complains of general malaise, debility of all the functions, poor appetite, abiding weakness in the back and spine, fugitive neuralgic pains, hysteria, insomnia, hypochondriasis, disinclination for consecutive mental labor, severe and weakening attacks of sick headache, and other analogous symptoms, and at the same time gives *no evidence of anemia or of any organic disease*, we have reason to suspect . . . that we are dealing with a typical case of neurasthenia." If this nosological conception suffers from the fault of a somewhat excessive inclusiveness, it is at all events to Beard's credit that he called emphatic and repeated attention to the occurrence and the reality of symptoms of the kind here described, some of which we now recognize as characteristic of one or another of the psychoneuroses. The seminal character of Beard's conception is indicated in the fact that in 1894, twenty-five years after the publication of his original article, Muller was able to compile a bibliography on "neurasthenia" of no fewer than fourteen pages. Furthermore, we find displaced to this field a debate between somatic and psychological similar to that which so long ruled in the field of "insanity." For example, for Déjerine the true psychoneuroses embraced only hysteria and neurasthenia, as the two conditions

⁵⁴ To this claim the *American Journal of Insanity* took exception (XXXVI, 1879-80, 521), citing an article by E. H. Van Deusen, entitled "Observations on a Form of Nervous Prostration (Neurasthenia), Culminating in Insanity" (XXXVI, 1879-80, 521). Originally a supplement to his Annual Report for 1867 and 1868, the article appeared in pamphlet form in February, 1869, and was republished in the *Journal* in April, 1869 (XXXV, 445). In it, the author says of the term neurasthenia, "It is an old term, taken from the medical vocabulary, and used simply because it seemed more nearly than any other to express the character of the disorder." Beard's original article was published in the *Boston Medical and Surgical Journal* of April 29, 1869.

As for the word "neurasthenia," both Beard and Van Deusen were mistaken, if the *New English Dictionary* is correct in stating that the word is first found in R. G. Mayne's *An Expository Lexicon of the Terms, Ancient and Modern, in Medical and General Science* (London, ed. of 1856).

⁵⁵ In the preface to *A Practical Treatise on Nervous Exhaustion (Neurasthenia) Its Symptoms, Nature, Sequences and Treatment* (New York, Wood, 1880).

which alone claim a disorder of the emotions as their primary etiology and which alone are traceable to an emotional cause, whereas Moebius, favoring a physical cause, looked upon neurasthenia as a kind of chronic intoxication by fatigue substances, a view which Kraepelin quoted with approval. But it remained for Freud, in 1895, at the very beginning of his career, to make the attempt to distinguish "from all that Beard included under the term neurasthenia . . . all those neurotic disturbances of which the symptoms, on the one hand, are more closely related to one another than to the typical symptoms of neurasthenia (headache, spinal irritation, and dyspepsia with flatulence and constipation), and, on the other hand, show in their aetiology and their mechanism essential differences from typical neurasthenia."⁵⁶ On the same subject, Binswanger, in 1896, had this to say: "Neurasthenia especially has been described as essentially a modern disorder, and Beard, to whom we are first indebted for a general description of it, believed that he had discovered a new nervous disease which had developed specifically in America. This assumption was of course erroneous; nevertheless the fact that an *American* physician was the first to perceive and maintain—as the fruit of great experience—the particular symptoms of this disorder cannot fail to point to a close connection between them and the modern way of life"⁵⁷—an etiology upon which Freud's later comment was that "the injurious influence of culture reduces itself in all essentials to the undue suppression of the sexual life in civilized peoples (or classes) as a result of the 'civilized' sexual morality which prevails among them."⁵⁸

From this comment of Freud's it is a simple transition to a rather singular figure who was as obscure, however, as his contemporary Beard was well known. For A. J. Ingersoll, to whom I refer, said that "hysteria is frequently caused by the voluntary suppression of the sexual life"; it was not, of course, by reason of this statement alone that Dr. A. A. Brill has called him an American precursor of Freud.⁵⁹ Ingersoll's book, *In Health*, which went into a second edition fifteen years later, was first

⁵⁶ Freud, "Ueber die Berechtigung, von der Neurasthenie einen bestimmten Symptomenkomplex als 'Angstneurose' abzutrennen," *Neurol Zentralblatt*, No 2 (1895) (Reprinted as "The Justification for Detaching from Neurasthenia a Particular Syndrome: the Anxiety Neurosis," *Collected Papers*, I, 76)

⁵⁷ Binswanger, *Die Pathologie und Therapie der Neurasthenie* (Jena, G Fischer, 1896); quoted by Freud, *Collected Papers*, II, 79

⁵⁸ Freud, "Die 'kulturelle' Sexualmoral und die moderne Nervosität," *Mutterschutz*, IV (1908) ("Civilized' Sexual Morality and Modern Nervousness," *Collected Papers*, II, 76)

⁵⁹ A A Brill, "An American Precursor of Freud," *Bull. of the New York Academy of Medicine*, XVI (1940), 631.

published in Boston in 1877—the same year as that in which appeared a work of much wider renown, S. Weir Mitchell's *Fat and Blood*. In offering psychological interpretations of their symptoms to his patients, Ingersoll seems to have evidenced an intuitive insight into certain psychological mechanisms whose existence, to say nothing of the fact that physical symptoms could be created by them, had scarcely received recognition in the eighteen seventies.⁶⁰ "At all events," says Brill, "Dr. Ingersoll was the first American physician to my knowledge who stressed the sexual factors in the neuroses."

In this general connection, reference may be made to Kiernan's reminder⁶¹ that Amariah Brigham made a few experiments with hypnotism as early as 1841,⁶² and that John M. Galt had discussed it at some length in his *Treatment of Insanity* (1846);⁶³ and also to the statement of C. H. Hughes⁶⁴ that Amariah Brigham was the first to show, "about 1840," that "dyspepsia" "usually has its origin in the brain."⁶⁵ In this same paper, indeed, Hughes reviewed a considerable list of medical and surgical disorders which he believed to "proceed from the brain," or in which a nervous element was contributory, and in particular emphasized the psychological background of "dyspepsia"—a diagnosis which we should now suppose to have included many cases of peptic ulcer.⁶⁶ He remarked that "As we recognize psychic influence over our physiologic life, over our physical and mental habits, so must we come to acknowledge it more

⁶⁰ For example, a foreshadowing of the workings of the superego and of repression could be said to occur in such a statement as, "We are so constituted that we cannot look with a condemnatory spirit upon any part of our organism, without creating disease in that part." As another example, Ingersoll not only recognized the existence of what later came to be sometimes known as the "masculine protest," but was willing to ascribe a patient's symptomatology to it—as when he told a girl who was unable to move, speak, or even whisper, and had not menstruated in eighteen months, that she had no organic disease, but that her condition was due to "anger at her catamenial function."

⁶¹ James G. Kiernan, "Hypnotism in American Psychiatry Fifty Years Ago," *Am J Insanity*, LI (1894-95), 336.

⁶² Annual Report of the Hartford Retreat, 1842 (cited by Kiernan).

⁶³ Kiernan, *op cit*

⁶⁴ C. H. Hughes, "The Nervous System in Disease and the Practice of Medicine from a Neurologic Standpoint," *J Am Med Assn.*, XXII (1894), 897.

⁶⁵ Amariah Brigham, *Remarks on the Influence of Mental Cultivation and Mental Excitement upon Health* (2d. ed., Boston, Marsh, Capen & Lyon, 1838) "But I apprehend that in a majority of cases dyspepsia is primarily a disease of the brain and nervous system" (p. 103).

⁶⁶ "Dyspepsia belongs to the brain-working, brain worrying and nerve tone exhausting element, to those who bother their brains and eat little or not over much, rather than to those who gormandize, to those who burn the midnight oil in study, do not sleep from fret and worry and carking care, rather than to the *bon vivant* high liver and he who tarries long at the wine. It belongs to the men of affairs and women of care, to the infelicitous and the disappointed in hope and ambition." *Ibid.*, p. 899.

generally in our dealings with disease."⁶⁷ If this acknowledgment was to be of somewhat slow growth on the whole, achieving only in rather recent years a development which has become almost a specialty in itself, under the designation of psychosomatic medicine, all the greater was the insight (easy to underestimate in retrospect) of such clinicians of fifty to one hundred years ago as, among others, Hughes and Ingersoll and the founder of the *American Journal of Insanity*.

Among the few papers with a psychological orientation, *strictori sensu*, published in the two or three years immediately before and after 1890, we find in the first volume of the *American Journal of Psychology*, newly founded by G. Stanley Hall, a study of dreams.⁶⁸ To anticipate somewhat, we find in the same journal, in 1902 (thus antedating by three years Freud's *Drei Abhandlungen zur Sexualtheorie*), a statement by Dr. Sanford Bell, that "the emotion of sex love . . . does not make its appearance for the first time at the period of adolescence, as has been thought."⁶⁹ To return to the first volume of the *American Journal of Psychology*, we find also the statement by Henry Smith Williams that "the psychical phenomena of dreams, subjectively considered, afford the best clue we can obtain to the delusions of the insane."⁷⁰ In the *Journal of Insanity*, we find a paper by Charles W. Page, then Superintendent of the Danvers Lunatic Hospital, on "The Adverse Consequences of Repression"⁷¹—noteworthy if only because the term repression does not seem to have been of very wide psychiatric occurrence in 1893.⁷² Nevertheless, the author of this paper states not only that "adverse consequences from

⁶⁷ *Ibid.*, p. 902.

⁶⁸ Julius Nelson, "A Study of Dreams," *Am. J. Psychol.*, I (1887-88), 367. The author "took up the study of dreams as a convenient portal to the general subject of hallucinations," for which purpose he collected over two thousand of his own dreams. Freud did the same, but with a different result, for Nelson's article does not deal at all with the content of his dreams, but only with their external phenomenology.

⁶⁹ "A Preliminary Study of the Emotion of Love between the Sexes," *ibid.*, XIII (1902), 325.

⁷⁰ Henry Smith Williams, "The Dream State and Its Psychic Correlations," *Am. J. Insanity*, XLVIII (1891-92), 445. Cf. the 1844 statement of Laycock, cited above.

⁷¹ *Am. J. Insanity*, XLIX (1892-93), 373.

⁷² The word is not given, for example, in Hack Tuke's *A Dictionary of Psychological Medicine, Giving the Definition, Etymology and Synonyms of the Terms Used in Medical Psychology*, etc (Philadelphia, Blakiston, 1892). While the term has now a predominantly psychoanalytic connotation, Freud himself having called the doctrine of repression "the foundation stone on which the whole structure of psychoanalysis rests, the most essential part of it," the idea denoted by the word was of course not original with Freud. It has been said by Otto Rank that the first specific formulation of the idea of repression occurs in Schopenhauer's *The World as Will and Idea* (1818). But until this passage was called to his attention by Rank, Freud supposed the doctrine of repression, since it "quite certainly came to me independently of any other source," to be entirely his own. See Freud, "On the History of the Psychoanalytic Movement," *Collected Papers*, I, 297-298.

repressed emotional sentiments appear in many conditions of mental disorder"—in states of melancholia as well as in acute mania—but also that auditory hallucinations represent the escape from repression of repressed ideas and wishes: "Auditory hallucinations are exceedingly liable to voice ideas and suggestions which the subject of them has endeavored to rule out of his mind and life, or which he has contemplated only with fear and trembling, thus linking them the more closely to his personality and rendering them the most aggressive thoughts in his mind."⁷³ The author further thought that to the same class must be assigned certain dreams—"which by their vivid and shocking details frequently torment disquieted individuals."⁷⁴

It may be noted at this point, as we approach the semicentennium (1894) of the Association of Medical Superintendents, and simultaneously the halfway point in one hundred years of American psychiatric literature, that the last quarter of the last century saw the founding of eight periodicals in the field of psychiatry, in addition to the three already mentioned.⁷⁵ Of these eight the first and one of the more important, surviving to the present day, was *The Chicago Journal of Nervous and Mental Disease*, founded in 1874; its name changed with its third volume (1876) to *The Journal of Nervous and Mental Disease*. The others were: *The Quarterly Journal of Inebriety*, published under the auspices of the American Association for the Cure of Inebriates, founded in 1876

⁷³ Baillarger (1809-1890), founder of the *Annales Médico-psychologiques*, "was the first to sense that hallucinations are what we would call today spontaneous results of a psychological reaction" (Zilboorg, *op. cit.*, p. 396). Meynert (1838-1892), on the other hand, believed them to be due to subcortical irritation (Zilboorg, *op. cit.*, p. 441)

⁷⁴ Page continues "Horrid dreams (of this stamp) are not uncommon, and they produce a depressing influence which can scarcely be shaken off during the waking hours. A sense of responsibility seems to hang over the heads of persons who suffer from this cause, although they repudiate the faintest suggestion that their dreams are the 'sequel of their waking thoughts'. . . Intense desire, and cravings which cannot be gratified, for the time being at least, stand in the same relation to the mind as do the repressed emotional sentiments or suggestions. Although of milder force, and innocent of the like after-effects, they come into the consciousness in the same spontaneous manner whenever the reasoning power of the mind is off guard. This is frequently demonstrated by dreams in which one seems to have realized an ardently longed-for object."

One should also note the author's unwitting description of the sufferer from compulsion neurosis, in the words in which he speaks of those who "pursue the journey of life burdened by a sense of responsibility, questioning this and doubting that, until their rational strength of purpose is neutralized by a sense of trepidation"—or, as one might say, the native hue of resolution is sicklied o'er with the pale cast of thought

⁷⁵ That is, *The American Journal of Insanity* (1844), the short-lived *American Psychological Journal* (1853), and *The Quarterly Journal of Psychological Medicine and Medical Jurisprudence* (1867), which went out of existence in 1876.

—in 1907 it became *The Journal of Inebriety*, the official organ of the American Society for the Study of Alcohol and other Narcotics, ceasing publication in 1914; *The Alienist and Neurologist*, a quarterly journal of scientific, clinical, and forensic psychiatry and neurology, founded in 1880, and continuing publication until April, 1920; *The American Journal of Neurology and Psychiatry*, devoted largely to abstracting the literature, founded in 1882 but ceasing publication after less than three volumes had appeared; *The American Psychological Journal*, issued by the National Association for the Protection of the Insane and Prevention of Insanity, founded in 1883, but surviving only from March, 1883, to October, 1884; *The Review of Insanity and Nervous Disease*, a quarterly compendium of the current literature of neurology and psychiatry, founded in 1890, and continuing publication through the first issue of the fifth volume in September, 1894, *The State Hospitals Bulletin*, published at Utica, New York, through the years 1896 and 1897, and continuing through 1901 under the title of *The Archives of Neurology and Psycho-pathology*, under the auspices of the New York State Hospitals and the Pathological Institute; and *The Journal of Psychoasthenics*, devoted to the care, training and treatment of the feeble-minded and of the epileptic, published by the Association of Medical Officers of American Institutions of Idiotic and Feeble-minded, founded in 1896, and still published, now by the American Association on Mental Deficiency, under the title adopted in 1940, *The American Journal of Mental Deficiency*. Of the eleven periodicals here cited, three are still in existence, after one hundred, seventy, and forty-eight years, respectively.

The first fifty years of the Association of Medical Superintendents of American Institutions for the Insane (after 1892, the American Medico-Psychological Association) and, likewise, the first fifty years of American psychiatric literature came to an end on a somewhat dramatic note—a note supplied by the Address before the Fiftieth Annual Meeting of the Association, delivered May 16, 1894, by Dr. Silas Weir Mitchell (1829–1914), army surgeon in the Civil War, Philadelphia neurologist internationally renowned for his use of the “rest cure,” and author of the widely popular *Wear and Tear, or Hints for the Overworked* (1871) and *Fat and Blood* (1877). In this Address, a survey of the status of American psychiatry at the mid-point of its centennium,⁷⁰ Dr. Mitchell could assuredly not be said to have set down aught in malice. But with equal certainty

⁷⁰ Am Medico-Psychological Assn, *Proceedings*, I (1895), 101.

it might be said that he extenuated nothing, or very little, in his pointing out of the little done, the undone vast, in the field of the care and treatment of the mentally disordered. Indeed, it would be as absurd to deny the justice and the deservedness of some of Dr. Mitchell's strictures as it would be to disregard the fact that, the human spirit and the human mind being what they are, the real wonder is that accomplishment and progress have been achieved to the extent they have, rather than that they have not been greater or more rapid.

Some of the defects to which Dr. Mitchell eloquently alluded were at the time, and had been for some years, in process of correction; indeed, he himself expressed the conviction "that within ten or fifteen years things have been improving, and that within your own ranks are men who had early seen and still see the need for much of what I urge today."⁷⁷ One of these defects, and one which Weir Mitchell stressed particularly, was that of scientific unproductiveness, of a lack of that scientific spirit which pervades hospitals for the bodily sick and injured.

I can but partially admit [he said] this endless plea of overwork in extenuation of the charge of scientific unproductiveness, the serious symptom of a larger malady. . . . Want of competent original work is to my mind the worst symptom of torpor the asylums now present. . . . To compare your annual output with the great English or German work were hardly a pleasant thing to do. Even in your own line, most of the text-books, many of the ablest papers, are not asylum products. What is the matter? You have immense opportunities, and, seriously, we ask you experts, what have you taught us of these 91,000 insane whom you see or treat?⁷⁸

But in 1893, the year before this far from groundless charge was leveled against a system in which the hospital at Utica, under John P. Gray, had stood out as one of the very few conspicuous exceptions, the first pathological laboratory "instituted with proper regard for the interrelation of clinical medicine and pathology" was established at the Illinois Eastern Hospital for the Insane, at Kankakee, by Dr. Adolf Meyer⁷⁹—the same year

⁷⁷ Dr. E. C. Spitzka, whom the *Journal* calls "also one of the earliest, ablest and most energetic advocates of asylum reform in this country," had written in reply to Weir Mitchell's questionnaire "On the whole I should state the condition of psychiatry in America to have improved in every respect, and I think the main improvement has occurred within the ranks of those who are physicians to asylums themselves. . . . It is safe to say that where ten years ago such phenomena as the pupillary reactions, other deep and superficial reflexes, defects in motor and sensory innervation, were studied by one asylum physician, they are today studied by fifty." *Am J Insanity*, LI (1894-95), 102-103.

⁷⁸ *Am Medico-Psychological Assn, Proceedings*, I (1895), 109-110.

⁷⁹ C. R. Bardeen, "Scientific Work in Public Institutions for the Care of the Insane," *Am J. Insanity*, LV (1898-99), 465.

in which August Hoch was appointed Pathologist at the McLean Hospital in Waverley, Massachusetts.⁸⁰ In 1896 the Pathological Institute of the New York State Hospitals was established under Dr. Ira Van Gieson as its first director. At twelve institutions of the twenty-two included in the Half-Yearly Summary of the 1897-98 volume of the *American Journal of Insanity*, laboratories had been begun or were in preparation; while in Michigan it was proposed to unite the State Hospitals with the State University at Ann Arbor "for the development of pathological work after the manner inaugurated by the New York State Hospitals in their Pathological Institute."⁸¹ Indeed, one cannot but note with some interest that Weir Mitchell's Semicentennial Address coincided with, rather than was to any very demonstrable degree instigatory of, the "infusing of new blood into a science which here and there shows traces of anemia,"⁸² that rebirth and extension of interest in the scientific study of mental disease which characterized the closing years of the last century.⁸³

⁸⁰ *Am. J. Insanity*, I (1893-94), 474.

⁸¹ *Ibid.*, LIV (1897-98), 309

⁸² "Notes and Comment The Progress and Promise of Psychiatry in America," *ibid.*, LIV (1897-98), 638

⁸³ It would appear that Dr Landon Carter Gray, a well-known neurologist of New York, followed closely in the footsteps of his more famous colleague, for he is reported as saying, at the 1896 meeting of the American Neurological Association, that in analyzing the record of American asylums, "we are startled to find that no new type of mental disease, no original pathological observation, no new departure in treatment, and not one text-book, has ever come from an American asylum, despite the millions of dollars and thousands of patients they have had at their command" To this the *Journal* offered in rebuttal. "We cannot think that, taking up his charges separately, he was unaware that acute delirium is often called Bell's disease, from its early describer, an American alienist [Luther V. Bell, "On a Form of Disease Resembling Some Advanced Stages of Mania and Fever, but So Contradistinguished from Any Ordinarily Observed or Described Combination of Symptoms, As to Render It Probable That It May Be an Overlooked and Hitherto Unrecorded Malady," *Am. J. Insanity*, VI (1849-50), 97], and that Dr. Van Deusen anticipated Beard in his description and designation of neurasthenia [E. H. Van Deusen, "Observations on a Form of Nervous Prostration (Neurasthenia), Culminating in Insanity," *ibid.*, XXV (1868-69), 445] It is possible he never studied the history of American psychiatry, but if he had he would have known that the first American alienists were ahead of their time in their own specialty, and pioneers in others, as Dr. Godding demonstrates in his paper in this issue of the *Journal* [W. W. Godding, "Then and Now, Being Pictures from the Past," *ibid.*, LIII (1895-96), 214] As to new departures in treatment, there have been, it is true, no epoch-making innovations Tuke and Pinel and their collaborators antedated all American psychiatry, but we can say with truth that Scotland, the advanced land of asylum reform of the present day, owes its first start in this direction to American counsel and example As regards text-books, his statement is not literally correct, for one excellent manual, at least, has issued from an American institution [presumably John M. Galt's *Treatment of Insanity*, 1846], and we might, perhaps, include that of Dr. Spitzka [*Manual of Insanity*, 1883]. . . There was a time when American psychiatry showed, to a certain extent, a reactionary and

This rebirth of interest in the scientific study of mental disease paralleled, if it also followed at a certain distance upon, a similar rebirth abroad, where it had received its inspiration in Germany from the work in particular of Kraepelin and of Wernicke, the psychiatric descendants of Kahlbaum. These two, together also with Ziehen and Sommer, gave the major impetus to the revival of active interest in psychiatry, stemming "the tide of traditionalism and of microscopical and 'spinal' psychiatry" and emancipating psychiatry from the "peculiar position of an adjunct to neurology."⁸⁴ In particular, Kraepelin's great merit, as stated by Adolf Meyer, lay in having "reduced a number of dogmatic general considerations to their actual *value in the stream of events in the life of definite patients*";⁸⁵ stated otherwise, "not the mental symptom constitutes the disease, but the general pathological evolution of the symptoms, physical and mental."⁸⁶ In the words of August Hoch, "The new impulse which is everywhere felt in the study of psychiatry depends largely on the fact that the necessity of clinical observation has become more thoroughly appreciated."⁸⁷

The foregoing found expression and amplification in such articles in the American periodical literature of this period as the following: August Hoch, "Kraepelin on Psychological Experimentation in Psychiatry"⁸⁸ and

unprogressive tendency, but that cannot be said to be the case at the present time . . ." *Am J Insanity*, LIII (1895-96), 324-325

With respect to scientific unproductiveness, Dr Adolf Meyer was to say ten years later, in words as different as possible from Weir Mitchell's, yet in something of the same sense "The psychiatric literature in the English language has nevertheless matured very creditable works, partly direct elaborations of personal experience, partly elaborations along the lines of French and German pioneers. For some reason there is, however, a rather striking uniformity and an absence of definite schools of research which not only would bring out stimulating contrasts, but also would prompt individuals to concentration on specially fruitful topics, in preference to endless generalities. We find especially prominent therapeutic ambitions . . . This explains why a high development in many of the practical measures grows side by side with a striking traditionalism and nominalism, and why the psychiatry of most writers cannot escape the comment that it is much more concerned with the adaptation of the mass of facts to a limited traditional set of terms than with a free and unprejudiced analysis and progressive grouping of the facts as they are. This is not as severe a criticism as might seem at first sight. Under the formal shell, a sound practical sense exists." Adolf Meyer, "A Few Trends in Modern Psychiatry," *Psychol Bull*, I (1904), 217.

⁸⁴ Meyer, *loc. cit.*

⁸⁵ *Ibid*, p. 230.

⁸⁶ Meyer, "A Short Sketch of the Problems of Psychiatry," *Am J Insanity*, LIII (1896-97), 538

⁸⁷ "A Review of Some Psychological and Physiological Experiments Done in Connection with the Study of Mental Diseases," *Psychol Bull*, I (1904), 241

⁸⁸ *Am J. Insanity*, LII (1895-96), 387

"Kraepelin on Katatonia";⁹⁸ Adolf Meyer's exhaustive review and discussion of the fifth edition (1896) of Kraepelin's *Psychiatrie*,⁹⁹ Adolf Meyer, "A Short Sketch of the Problems of Psychiatry",¹⁰⁰ Peterson and Langdon, "Katatonia";¹⁰¹ W. L. Worcester, "The Katatonic Symptom-Complex";¹⁰² August Hoch, "On the Clinical Study of Psychiatry";¹⁰³ Adolf Meyer's review of the second edition of Ziehen's *Psychiatrie*,¹⁰⁴ Adolf Meyer, "A Review of Recent Problems of Psychiatry"¹⁰⁵ (a very thorough survey of late nineteenth-century German psychiatry, with special reference to the place of Kraepelin, Wernicke, Ziehen, and others); Adolf Meyer, "A Few Trends in Modern Psychiatry",¹⁰⁶ August Hoch, "A Review of Some Psychological and Physiological Experiments Done in Connection with the Study of Mental Diseases";¹⁰⁷ F. X. Dercum, "The Heboid-Paranoid Group (Dementia Praecox)—Clinical Relations and Nature."¹⁰⁸

In the meantime, Adolf Meyer was voicing, as "the fundamental principle on which the psychiatry of today is based," the biological conception of man which views the living person as a being to be studied by the methods of anatomy, physiology, and psychology. "We know now that we must attack the problem from the biological side, from the point of view of *mental* pathology and of *physiological* pathology."¹⁰⁹

There also appeared in the psychiatric literature of this period a trend in the direction of replacing the attempt to found psychiatry upon an anatomical basis (to find anatomical explanations for mental phenomena) with an attempt to found it upon a chemical basis—a procedure possibly suggestive of the German phrase, *den Teufel mit Beelzebub austreiben*. This was the point of view summarized by F. X. Dercum in 1895, in an address before the Medical Society of the State of Pennsylvania;¹¹⁰ and he was followed in this two years later by Dr. Ira Van Gieson who, "in agreement with many investigators of the present period," expressed the opin-

⁹⁸ *Ibid*, p. 561

⁹⁹ *Ibid.*, LIII (1896-97), 298.

¹⁰⁰ *Ibid*, p. 538

¹⁰¹ *Med Record*, Oct 2, 1897, abstracted in *Am J. Insanity*, LIV (1897-98), 471

¹⁰² *Am J Insanity*, LV (1898-99), 569.

¹⁰³ *Ibid*, LVII (1900-1901), 281.

¹⁰⁴ *Ibid*, LIX (1902-3), 353.

¹⁰⁵ In Church and Peterson, *Nervous and Mental Diseases* (4th ed., Philadelphia, Saunders, 1904), pp 650-688.

¹⁰⁶ *Psychol. Bull*, I (1904), 217.

¹⁰⁷ *Ibid*, p. 241.

¹⁰⁸ *Am. J. Insanity*, LXII (1905-6), 541.

¹⁰⁹ Meyer, "A Short Sketch of the Problems of Psychiatry," *ibid.*, LIII (1896-97), 538

¹¹⁰ "Address on Mental Diseases," May 21, 1895, *J. Am. Med Assn.*, XXIV (1895), 937.

ion that "the majority of diseases of the nervous system (including diseases of the mind) are to be led back to one form or another of 'poisoning,'"¹⁰² the toxic substances in question being absorbed or ingested from without, or produced by altered tissue metabolism, or elaborated by bacteria. A similar thought occurs in P. M. Wise's Presidential Address before the American Medico-Psychological Association in 1901:

We are being gradually drifted by clinical experience and the physiological laboratory to the conclusion that the vitalizing element of cell integrity depends more upon chemical processes than upon structure, and that we may have marked digressions from the normal without structural change . . . The indications are that initial mental pathology is of a chemical nature, and leaves no traces in structure in the non-living tissues discoverable at least by present technique.¹⁰³

This latest form of the desire to study the insane by modern scientific methods, this renewed attempt to make psychiatry scientific—which thirty-five years later Dr. Macfie Campbell described as "not so dissimilar to what may frequently be seen today, where the attempt to make psychiatry scientific is likely to result in the disappearance of psychiatry from the program"¹⁰⁴—gave rise, at all events, to one outstanding piece of work, even though its results were negative: namely, the metabolic studies which Otto Folin carried out at the McLean Hospital.¹⁰⁵ In the course of metabolic investigations constituting "the most complete and extensive experiments on record in connection with the insane," Folin developed micro-methods of chemical analysis upon which no little of his reputation as a chemist rests. He reported that, apart from the strong suggestion that "in general paralysis we have a disease which may be associated at one stage or another with some demonstrable metabolic disorder," it was "impossible to identify any one metabolism peculiarity with any particular form of mental disorder." From another source negative results were reported from an investigation of "autointoxication or more properly autoinfection" in acute depressive psychoses.¹⁰⁶ Even where it was possible

¹⁰² "Notes and Comment," *Am. J. Insanity*, LIV (1897-98), 618

¹⁰³ *Am. J. Insanity*, LVIII (1901-2), 79.

¹⁰⁴ C. Macfie Campbell, "Adolf Meyer," *Arch. Neurol. and Psychiatry*, XXXVII (1937), 715

¹⁰⁵ "Some Metabolic Studies, with Special Reference to Mental Disorders," *Am. J. Insanity*, LX (1903-4), 699, LXI (1904-5), 299

¹⁰⁶ Victor C. Myers, Jessie W. Fisher, and A. R. Diefendorf, "The Question of Autointoxication in Acute Depressive Psychoses," *ibid.*, LXV (1908-9), 607 "It would seem that in the psychoses studied, the question of autointoxication or more properly autoinfection was one which should always be considered, at least as an influencing factor, although at the present time the analytical data are insufficient to ascribe definitely certain nervous or other disorders to an autointoxication."

to show that in this or that respect the mentally ill were physiologically different from the mentally well, it was not possible to show that the way in which they differed had any specific character, such that it was invariably present in the presence of a given mental disorder and absent in its absence.

A brief digression is necessary in order to note that to the proceedings growing out of the assassination of President William McKinley on September 6, 1901, the *American Journal of Insanity* gave much less space than to the case of Guiteau, the assassin of President Garfield, exactly twenty years earlier. The question at issue was much less in doubt; it was apparently as much the general opinion as it was that of Dr. Carlos F. MacDonald that "Leon F. Czolgosz on September 6, 1901, when he assassinated President McKinley, was in all respects a sane man—both legally and medically—and fully responsible for his act."¹⁰⁷ But on the basis of a painstaking investigation of Czolgosz's life history and of his mental condition for some years prior to his crime, subsequently carried out by Dr. L. Vernon Briggs at his request, Dr. Walter Channing concluded that very little doubt of the assassin's insanity could be entertained.¹⁰⁸

We return to the renewal and especially to the extension of interest in the study of mental disease which characterized the turn of the century and the years immediately following—an evolution in which, *inter alia*, the "disciples of the microscope"¹⁰⁹ tended to be displaced by those of the ward and bedside. A major inspiration of this evolution was the influence of Kraepelin, particularly as transmitted and carried into effect, to a greater degree than at the hands of any other single American psychiatrist, by Adolf Meyer.

With or without benefit of Kraepelin, signs were not lacking of at least the beginnings of a certain reorientation toward the problems of mental disorder, indications of which in certain directions have already received some mention. Reference has already been made to an early instance, dating from 1893, of a purely psychological approach, in that Dr. Page

¹⁰⁷ Carlos F. MacDonald, "The Trial, Execution, Autopsy and Mental Status of Leon F. Czolgosz, Alias Fred Nieman, the Assassin of President McKinley," *ibid*, LVIII (1901-2), 369.

¹⁰⁸ Walter Channing, "The Mental Status of Czolgosz, the Assassin of President McKinley," *ibid*, LIX (1902-3), 233. In *The Manner of Man That Kills* (Boston, R. G. Badger, Gorham Press, 1921), Dr. Briggs set forth the data of his investigation of the Czolgosz case, the book also containing a study of two psychopathic murderers, Spencer and Clarence V. T. Richeson ("the only man ever executed in Massachusetts without a trial").

¹⁰⁹ G. Alder Blumer, "Presidential Address," delivered before the American Medico-Psychological Association, May, 1903, *Am J Insanity*, LX (1903-4), 1. In this Address the speaker quoted an aphorism from the *British Medical Journal* of January 17, 1903: "A finger-post for future guidance is a more lasting memorial than a mausoleum of misdirected energy."

regarded a case from the standpoint of the psychological mechanisms which seemed to him to be involved—specifically, those of *repression*, as stated in his title,¹³⁰ and of *regression*,¹³¹ without recourse to either microtome or test-tube, it was clear to him that in the coprolalia which was the presenting and most conspicuous symptom of the psychosis of a girl “of angelic purity and Christian womanhood,” “she must have given expression to ideas and language which represented, in some sense, her mental endowment.”

In 1899 there appeared in the *American Journal of Insanity* an article by Boris Sidis, entitled “The Nature and Principles of Psychology.”¹³² In this it was stated, in words touched with a certain irony, that “A psychic fact is something that cannot be put in any hardening fluid, nor cut into slices, nor put on slides, nor stained, nor put under the microscope and then represented in so many figures and pictures. In short, it is mere thought. And what is thought? Metaphysics! Cells and stains, that is real science!” In the same volume, of the *Journal* Professor Hyslop of Columbia University, also not a psychiatrist, is quoted (although with marked disapproval) as saying that “If hallucinations, apparitions, automatisms, dowings, and things of this sort were studied in this country with as much care as Pierre Janet has bestowed upon them in France, there would be a chance of discovering a cure for certain forms of insanity”¹³³—a statement whose overoptimism does not nullify the insight it evidenced.¹³⁴ In an

¹³⁰ “The Adverse Consequences of Repression.” It is almost unnecessary to say that, as is clear enough from the article, the writer is really referring to “the adverse consequences of” the return of the repressed from repression.

¹³¹ “Insanity is essentially the reduction of mental operations from higher to lower planes of action. While the same fundamental laws of mental action prevail through life, the purposes, promptings and springs of action in the mature mind of a sane man are not transparent, and are not easily comprehended. But the conditions are often otherwise with the insane, where the thoughts and actions are true to nature . . . When the refining ideals which characterize society are inoperative, and when the egoism of sense has superseded the egoism of reason, all restraint is cast aside, and consequences of every nature and degree are unheeded” (p. 376).

¹³² *Am J Insanity*, LVI (1899-1900), 41.

¹³³ *Ibid.*, 722.

¹³⁴ In this whole connection, it is interesting to find the English psychiatrist, T. S. Clouston (whose *Lectures on Mental Diseases*, 1883, was called by the *Journal* “the most attractive, instructive and practical of all our text-books”), quoted two years earlier as expressing the belief “that we are on the eve of an enormous extension of our definite knowledge in regard to the relationship of mind and brain. Great, perhaps startling, generalizations on the subject seem to loom in the air, and until the man appears who will be able to shed the light of a great law on this, the most difficult of all scientific problems . . .” *Am J Insanity*, LIV (1897-98), 638. Few would today dispute that Freud was to be this man, out of whose ability to “shed the light of a great law” grew at all events the most systematized, and the most dynamic, theory of mental phenomena that we possess.

article written in 1902, E. Stanley Abbot cited the statement of Krafft-Ebing, which also expressed the position of "the majority of psychiatrists today," that "Insanity is a brain disease," since "it is a logical and self-evident consequence that the organ which under normal conditions subserves the purposes of psychical processes must be the seat of changes if these functions are disordered." Abbot denied it to be a "logical and self-evident consequence" that the brain is diseased because a man has a delusion—"it *may* be, but it yet remains to be proved that it *must* be." He emphasized that "the scientific study of insanity consists primarily in the study of the mental phenomena, not physical conditions," and that "the study of physical conditions is necessary . . . but of itself alone can never give us an understanding of insanity."¹¹⁶ In 1905, Robert Jones, writing from the London County Asylum,¹ remarked that it required courage, if not daring, "to advance at this stage of neurological research and knowledge the view that many of the morbid mental conditions known as insanity are functional, and that therefore there are diseases of function as well as of organs."¹¹⁸ In the same year Dr. Edward Cowles, perceiving a general "turning away from the barrenness of histological provings," believed "it might be said that the first step in the classification of mental diseases discovers two great divisions: Functional insanity and deteriorating insanity."¹¹⁷ In the preceding year the New York neurologist Charles L. Dana, addressing the Congress of Arts and Sciences at St. Louis, had said that "Clinical psychiatry is, in fact, only morbid psychology."¹¹⁸ In

¹¹⁶ "The Criteria of Insanity and the Problems of Psychiatry," *Am J Insanity*, LIX (1902-3), 1

¹¹⁶ "Functional Insanity and Its Relation to Allied Neuroses," *ibid*, LXI (1904-5), 671.

¹¹⁷ "The Problem of Psychiatry in the Functional Psychoses," *ibid*, LXII (1905-6), 189

¹¹⁸ *Am Med*, IX (1905), 97, quoted in *Am J Insanity*, LXII (1905-6), 340. An article published in the same year (1905)—J. W. Wherry, "Melancholia, the Psychical Expression of Organic Fear," *Am. J Insanity*, LXII (1905-6), 309—cannot be passed over without mention. For the author—who proclaims himself one of the lesser lights who "become bewildered when the leading alienists of the country cry aloud with one voice that all forms of insanity are due to abnormal bodily conditions, either located in the brain or elsewhere, while, at the same time, reports are published of various forms of insanity caused by disappointment or grief or some other psychical state"—not only removes the word "*emotion*" from the psychiatric Index Expurgatorius in which it was still embalmed, but discusses the emotions themselves as a *causa causans*. Amid much that does not seem very pertinent, he postulates "organic" or instinctive (as opposed to "ethical") emotions, which "are the basic elements of our natures. They are coexistent with life itself. They are the outgrowth of those three fundamental principles, self-assertion, self-preservation, and reproduction"—in Freudian terminology, narcissistic and object-libido. "But between the ethical emotions and the organic emotions there exists perfect peace and harmony only in the most favored individuals. With a large majority it is at best an unending struggle between protoplasm and ethics, between cell intelligence and education, between instinct and culture . . . The mind is not the fountain head and primal source of all human action, nor is the brain

1907, August Hoch boldly brought psychogenesis into the foreground in a paper read before the New York Psychiatric Society in March. He stated that among the paranoiac states there were cases, and they probably represented a large proportion, "in which the psychogenesis could be clearly traced, when the facts were really accessible"; in other words, certain paranoiac states were produced by purely mental causes, "that is, by conflicts and unhygienic ways of dealing with them." The author mentioned among those who had influenced his ideas not only Adolf Meyer but, for the first time in American psychiatric literature, Freud, Bleuler, and Jung.¹¹⁹

The expression of the general point of view which, as outlined in the preceding paragraph, achieved more or less fragmentary utterance through roughly the first decade of the present century reached a culmination in an article published by Adolf Meyer in 1908, entitled "The Role of the Mental Factors in Psychiatry."¹²⁰ Pointing to the effect upon pathology of the theory of immunity, such that the capacity of *resistance* to degrees of virulence had become an issue greater than a mere knowledge of the tissue changes, whence "the mere histologist has given way to the experimentalist, or rather, a *combination* of all the available facts, causal, functional and structural, has become the central thought of pathology," Dr. Meyer cited the case of a woman who, forced to move on two occasions, reacted each time with a depression.

We do well [said Dr. Meyer] to point to the constitutional peculiarity—a lack of immunity. Since there *are* cases in which we cannot find any precipitating factors, we are apt to spread ourselves on a statement of heredity and possibly degeneracy of make-up, of possible lesions, etc., and to overemphasize these issues. What we actually know is that this patient is apt to react with a peculiar depressive reaction where others get along with fair balance. The etiology thus involves (1) constitutional make-up, and (2) a precipitating factor. . . . It is my contention that we must use *both* facts, and that of the two, for prevention and for the special characterization of the make-up, the pre-

the sole repository, as well as originator, of all that a man thinks, feels and does. It is well to consider, and to realize, that in all the abnormal acts of civil and social life the organic emotions must be reckoned with. It is the body which is the *I*, and not the mind. . . . It moves, it breathes, it has its being, and, in spite of metaphysical teachings and religious dogmas, it holds the mind and all its attributes in the hollow of its hand. . . . These organic emotions are often the mainsprings of action, and in abnormal conditions of the mind they are always to be duly considered."

¹¹⁹ August Hoch, "The Psychogenetic Factors in Some Paranoiac Conditions, with Suggestions for Prophylaxis and Treatment," *Am J Insanity*, LXIV (1907-8), 189

¹²⁰ *Am J. Insanity*, LXV (1908-9), 39

precipitating factor is of the greater importance because *it* alone gives us an idea of the actual defect and a suggestion as to how to strengthen the person that he may become resistive. It is a problem of index of resistance with regard to *certain difficulties of mental adjustment*.¹²¹

. . . Some persons are immune and readily balanced, others get wrecked. The main question is, What makes the difference? Some talk of degeneracy, others of autointoxications, and still others of glia-overgrowth—but these statements are often mere conjectures or refer to merely incidental facts . . . And it has become my conviction that the developments in some mental diseases are rather the results of peculiar mental tangles than the result of any coarsely appreciable and demonstrable brain lesion or poisoning—the natural further development of inefficient reaction-types.

Why the dissatisfaction with explanations of a psychogenetic character? (1) Because the facts are difficult to get at, and difficult to control critically, and often used for stupid inferences, for instance, a notion that a psychogenetic origin—i e., a development out of natural mental activities which could not harm you or me—could not explain occasional lasting and frequently progressive disorders (in the face of the fact that nothing is more difficult to change than a political or religious or other deeply rooted conviction or tendency . . .). (2) Because there prevail misleading dogmatic ideas about mind.

To sum up: There are conditions in which disorders of function (possibly with definite lesions) of special organs are the essential explanation of a mental disorder—a perversion of metabolism by poison, a digestive upset, a syphilitic reaction or an antisymphilitic reaction of the nervous system, an arteriosclerosis; and in *these*, the *mental* facts are the incidental facts of the experimental chain. But there *are* cases in which the apparent disorder of individual organs is merely an incident in a development which we could not understand correctly except by comparing it with the normal and efficient reaction of the individual as a whole, and for that we must use terms of psychology—not of mysterious events, but of *actions* and *reactions*, of which we know that they *do* things, a truly dynamic psychology.

This article was one of a series of some half dozen from the pen of the same writer (and the only one to be published in the *American Journal of Insanity*) which appeared during the period 1903 to 1911—a group of

¹²¹ If Adolf Meyer found it necessary to say the foregoing in 1908, so did Freud twelve years earlier. For the latter wrote, in "Heredity and the Etiology of the Neuroses," "The specific, determining causes of neuropathy have been too little investigated, for the vision of physicians has been dazzled by the imposing prospect of the hereditary factor in etiology. Nevertheless, they are well worth making the object of careful study, although their pathogenic power may be in general only auxiliary to that of heredity, great practical interest centers on the understanding of this specific etiology. It affords a point of attack for our therapeutic efforts, while hereditary predisposition, predetermined for the patient from birth, frustrates all our efforts by the strength of its position."

articles which, collectively considered, form without any doubt, in their path-breaking character and their enormous influence upon American psychiatry, the most original and the greatest single contribution to American psychiatric literature. In the earliest of these papers, "An Attempt at Analysis of the Neurotic Constitution,"¹²² Dr. Meyer stated, although as a truism, that "a large number of those who become insane are individuals in whom a turn to the worse could be anticipated"; in the words of Kirby, "Prof. Meyer was the first to show how clear indications of tendencies toward defective adaptation could so often be recognized long before the obvious mental breakdown, in many cases even very early in life."¹²³ Dr. Meyer also remarked that Kraepelin, in the first number of his *Psychologische Arbeiten*, mentions that it is probable that the mental constitution of the neurasthenic, the hysterical, the paranoid, and the maniacal-depressive is different from the very start, but not only does he, Kraepelin, not "tell us of the actual distinctions," but in the same year, in the fifth edition of his textbook, "he turned around completely with regard to dementia praecox, of which he seemed to think that it was an autointoxication which any one could get."¹²⁴ Of the second of this series of Dr. Meyer's articles, "Fundamental Conceptions of Dementia Praecox," published in 1906,¹²⁵ Dr. Macfie Campbell, calling it "an important milestone in the history of psychiatry," said that it "excited comparatively little comment at the time, but the views presented in this paper and in subsequent papers slowly permeated the whole of modern psychiatric thought."¹²⁶ What it was that slowly permeated the whole of modern psychiatric thought was the conception of the personality behind the psychosis, the consideration of the psychosis (and of its symptoms) in the setting and against the background of the patient's behavior in his actual life situation—more specifically, the emphasis upon "the original endowment of the patient, the special traits of personality, the molding influence of the home, the formation of habits, the stresses of the actual situation."¹²⁷ Meyer opposed Kraepelin's explicit refusal to believe that

any antecedents in the life of the patient are worth considering as causal or even as exaggerating dynamic factors. About 20 per cent would, according to him [Kraepelin], show some early premonitory signs like seclusiveness,

¹²² *Am. J. Psychol.*, XIV (1903), 354.

¹²³ George H. Kirby, "Prognostic Principles in the Biogenetic Psychoses, with Special Reference to the Catatonic Syndrome," *Am. J. Insanity*, LXIX (1912-13), 3035.

¹²⁴ *J. Nerv. and Mental Dis.*, XXXVI (1909), 233.

¹²⁵ *Brit. Med. J.*, II (1906), 757.

¹²⁶ "Adolf Meyer," *Arch. Neurol. and Psychiatry*, XXXVII (1937), 715.

¹²⁷ *Ibid.*, p. 723.

oddity, excessive religious devotion—but he sees in this mere evidence of an early setting in of the so-called “disease itself.” But the cases in which early symptoms *are* found are much more numerous than 20 per cent; as I claimed in 1903, a very large number of these cases shows what Hoch has lately called a shut-in personality, specially exposed to inner friction.¹²⁸

In a word, the personalities which develop dementia praecox show, too often to be disregarded, early deficiencies in the instinctive life, faulty mental habits, inefficient application to reality, seclusiveness, peculiar judgment defects, and drifting away from concrete interests.¹²⁹ As Hoch expressed it, Meyer

laid especial stress upon the seriousness of using inadequate means for getting square with difficulties in life, and insisted upon the fact that when we are able to obtain an accurate anamnesis we find in the “normal life” an excessive use of reactions which bring a certain danger with them, such as the partial suppression of events, the substitutive activities, and the like; in addition should be mentioned brooding, or more serious reactions, such as empty harping, tantrums, grossly imaginative substitutions, in other words, means which do not adequately square up matters.¹³⁰

Meyer adds that there are surely among the so-called normal, or among those who do not develop psychoses, a great many shut-in personalities; but it was his belief that when these were compared with “the shut-in personalities that go wrong” there were differences, and it was “just those differences which seem to throw the weight into the scales for the worse.”¹³¹ “To try to explain a hysterical fit or a delusion system,” Meyer said, “out of hypothetical cell alterations which we cannot reach or prove is at the present stage of histophysiology a gratuitous performance. To realize that such a reaction is a *faulty response or substitution of an insufficient or protective or evasive or mutilated attempt at adjustment* opens ways of inquiry in the direction of modifiable determining factors.”¹³²

It seems to this writer that the influence of Freud is here hardly to be doubted, although it is certainly less considerable and less direct than Freud's influence, on the other hand, upon Bleuler, whose *Affektivität*,

¹²⁸ Meyer, “The Dynamic Interpretation of Dementia Praecox,” *Am. J. Psychol.*, XXI (1910), 385. This paper, by the way, was read on the same occasion, at Clark University in 1909, as that on which Freud had the first opportunity of his life of speaking in public on psychoanalysis.

¹²⁹ *Am. J. Insanity*, LXIX (1912-13), p. 1037.

¹³⁰ August Hoch, “The Psychogenic Factors in the Development of the Psychoses,” *Psychol. Bull.*, IV (1907), 161.

¹³¹ *J. Nerv. and Mental Dis.*, XXXVI (1909), 233.

¹³² “The Problems of Mental Reaction-Types, Mental Causes and Diseases,” *Psychol. Bull.*, V (1908), 245.

Suggestibilität, Paranoia and Freud'sche Mechanismen in der Symptomatologie von Psychosen appeared in 1906, and upon Jung, whose *Über die Psychologie der Dementia praecox* was published in 1907, followed in 1908 by Bleuler and Jung's joint paper on *Komplexe und Krankheitsursachen bei Dementia praecox*.¹⁸³ Dr. Meyer himself, while stating that we owe to Freud and Jung "the demonstration that what is at work in the center of the stage is a complex or group of complexes consisting of insufficiently balanced experience in various ways, modified by symbolism,"¹⁸⁴ contrasted two tendencies, "one of Freud and Jung, which emphasizes concrete experiences and reactive complexes thereto, and the less specific attempt to formulate the loss of balance attempted by me, on ground of habit deterioration and tantrums or more lasting reactions biologically unfavorable to restitution to a normal attitude",¹⁸⁵ in another place, Meyer spoke of "those of us who follow up principles rather less exclusive than Freud's, viz., the habit-disorganizations and the study of conflicts and their effects and their modifiability."¹⁸⁶

¹⁸³ In Jung's *Studies in Word Association* (with a foreword by Bleuler on the significance of association experiments), the view was put forward (in 1906) that the reactions to the so-called stimulus words are determined by "complexes" in the mind of the subject—a type of experiment "well suited," Freud has remarked, "to make us doubt the existence of chance and of what appears to be arbitrariness in mental processes." But in 1904 Freud had published a work (*The Psychopathology of Everyday Life*) in which he pointed out that a whole series of actions previously held to be due to chance were on the contrary strictly determined.

Bleuler—who introduced the term *ambivalence* into psychiatry (1910)—later manifested a considerable degree of ambivalence toward psychoanalysis; but eventually, in 1914, he had this to say: "I consider that up to the present the various kinds of psychology have contributed precious little towards an explanation of the underlying connections in psychogenic symptoms and diseases, but that the psychology of the depths [*Tiefenpsychologie*, referring unquestionably to psychoanalysis] offers something towards a psychology which still awaits creation; and I even believe that in my *Schizophrenie* I have taken a very short step towards the required understanding. The first two assertions are certainly correct, the last may be an error."

¹⁸⁴ *Am. J. Psychol.*, XXI (1910), 385.

¹⁸⁵ *J. Abnormal Psychol.*, V (1910-11), 274.

¹⁸⁶ *Psychol. Bull.*, V (1908), 245. In the same article, the author wrote "Jung now takes explicitly the attitude that the complex not only determines the 'content' of the abnormal developments and the secondary symptoms, but that it can have a role in the origination of the organic disease process. The great contribution of Bleuler and Jung to psychopathology is the splendid material they have furnished towards a deepening of the conviction that many abnormal mental developments are best understood along the lines of reactions to affective experiences, i.e., principles which also govern our normal mental life. . . . The bulk of the facts is in harmony with a psychogenic explanation not only of psychasthenia and hysteria but of a broad range of mental disorders. Only for the deterioration, Jung was tempted to appeal to a production of toxins. . . . We therefore see in psychopathology the study of abnormal behavior and of the modifiability of its determining factors" (pp. 248, 249, 252).

Certain papers by August Hoch belong also in this *Blutezeit* of American psychiatric literature; one of them, on the psychogenetic factors in some paranoiac conditions,¹³⁷ has already been mentioned. It was Hoch who coined the term *shut-in personality* to describe the general type of personality which he and Amsden found in a large percentage of cases of undoubted dementia praecox. The manic-depressive psychoses, on the other hand, develop in entirely different kinds of personalities; and it was Hoch's and Amsden's finding, besides, that a manic personality occurred chiefly in persons who had only manic attacks, next most frequently in those who had both manic and depressive attacks, but only very rarely in those who had only depressions.¹³⁸ In 1910, reporting on the analytic investigation of three cases of dementia praecox, one of which eventually made a recovery, Hoch remarked that

anyone who has analyzed cases of dementia praecox must have been impressed with the fact that the content often unmistakably refers to disharmonies in the sexual sphere, and this is, as we have reason to believe, not accidental, but due to a fundamental defect of sexual adaptation in its widest sense. It is essentially Freud and Jung to whom we owe our insight into these principles, which are at times more clearly in evidence in dementia praecox than in hysteria, though not fundamentally different from those of the neuroses and of everyday life.¹³⁹

Hoch also gave an excellent brief survey of this whole field in his address delivered at the opening exercises of the Henry Phipps Psychiatric Clinic, in April, 1913, entitled "Personality and Psychosis."¹⁴⁰ His concluding words were as follows:

What we desired to show in this brief discussion, in which only the main points could be touched, is, then, the frequency and the importance of abnormal manifestations in patients who later develop manic-depressive insanity and dementia praecox, and to point out the fact that the symptomatology of these manifestations has much in common with that of the psychosis. The same is found in the neuroses. These peculiar traits of the personality are more frequent in cases which develop the graver disorders, which we call dementia praecox, than in those which break down with the more benign manic-depressive attacks. In interpreting the facts it appeared to us that there is enough

¹³⁷ *Am. J. Insanity*, LXIV (1907-8), 189

¹³⁸ "A Study of the Mental Make-up in the Functional Psychoses," *J. Nerv. and Mental Dis.*, XXXVI (1909), 230

¹³⁹ "On Some of the Mental Mechanisms in Dementia Praecox," *J. Abnormal Psychol.*, V (1910-11), 255

¹⁴⁰ *Am. J. Insanity*, LXIX (1912-13), 887

reason to regard the relationship of personality and psychosis, even in the case of dementia praecox, from the point of view of faulty development or of defects of adaptation, in other words, as dependent upon a defective *Anlage*, which often shows itself in definite symptoms throughout life. Therefore, both the pathological personality, with its milder manifestations, and the psychosis, with its more complete break of compensation, may be looked upon as determined by constitutional factors, in the sense that when demands for adaptation arise, the individual is found unfit to meet them, unfit through inherent weakness, but also at times, to quite an extent, through false attitudes which have developed through lack of proper training. In this last direction lies our hope for modifying these defects.

A number of articles published in *The American Journal of Insanity* at this time reflect in varying degree the orientation outlined in the pages immediately preceding. In the 1909-1910 volume appeared a paper entitled "A Case of Schizophrenia (Dementia Praecox): an Analysis," by A. A. Brill,¹⁴¹ later to become the dean of American psychoanalysts; a paper by William Burgess Cornell, entitled "A Study of the Auto- and Somatopsychic Reaction in Four Cases of Dementia Praecox"¹⁴²—a piece of work based on Freud, Bleuler, and Jung; and two papers by Ernest Jones, then Demonstrator of Psychiatry at the University of Toronto but later to become the dean, and also *facile princeps*, of British psychoanalysts: "Psycho-Analytic Notes on a Case of Hypomania,"¹⁴³ and "On the Nightmare"¹⁴⁴—the latter becoming Part I of a volume published in 1931 under the title, in England, of *On the Nightmare* and, in this country, of *Nightmare, Witches, and Devils*. An article again owing its inspiration to Freud and Jung appeared in the next volume of the *Journal*, "Clinical Studies of the Psychic Factors Concerned in Functional Psychoses," by Charles F. Read.¹⁴⁵ The 1911-1912 volume of the *Journal* contained no fewer than four articles belonging also in this same general category.¹⁴⁶

This period saw also the first publication of a work which became a classic, particularly from the pedagogic standpoint, of American psychi-

¹⁴¹ *Ibid.*, LXVI (1909-10), 53.

¹⁴² *Ibid.*, p. 529.

¹⁴³ *Ibid.*, p. 203.

¹⁴⁴ *Ibid.*, p. 383.

¹⁴⁵ *Ibid.*, LXVII (1910-11), 705.

¹⁴⁶ That is, E. Stanley Abbott, "Meyer's Theory of the Psychogenic Origin of Dementia Praecox: A Criticism," *Am. J. Insanity*, LXVIII (1911-12), 15, Ernest Jones, "The Relationship between Dreams and Psychoneurotic Symptoms," *ibid.*, p. 57, Earl D. Bond and E. Stanley Abbot, "A Comparison of Personal Characteristics in Dementia Praecox and Manic-Depressive Psychosis," *ibid.*, p. 359 (this was followed a year later by Earl D. Bond, "Personality and Outcome in Two Hundred Consecutive Cases," *ibid.*, LXIX (1912-13), 731), and Bernard Glueck, "A Contribution to the Study of Psychogenesis in the Psychoses," *ibid.*, LXVIII, 371.

atric literature: William A. White's *Outlines of Psychiatry* (1907). It saw the expression in the literature of a certain interest in heredity in relation to mental disorder,¹⁴⁷ in Alzheimer's disease¹⁴⁸ (which Alzheimer first described in 1907), and in pellagra, on which six articles were published in two volumes of the *Journal*.¹⁴⁹ It saw the publication of Clifford W. Beers's *A Mind That Found Itself* (1908), and the forming of the National Committee for Mental Hygiene (1909). It saw, above all, the expression of a particular interest in provision for the care of sufferers from mental disorder in its earliest stages—in observation wards, psychopathic wards, and psychopathic hospitals.¹⁵⁰ This measure had been advocated by T. S. Clouston as far back as 1880, it is said, and it was carried into effect in 1902 at Albany (Pavilion F), in the State Psychopathic Hospital at the University of Michigan (1906), at New York (Bellevue), and in the Boston Psychopathic Hospital (June, 1912), and at the Henry Phipps Psychiatric Clinic (April, 1913).¹⁵¹ From the standpoint of American psychiatric liter-

¹⁴⁷ For example, A. J. Rosanoff and I. Florence Orr, "A Study of Heredity in Insanity, in the Light of the Mendelian Theory," *Am. J. Insanity*, LXVIII (1911-12), 221; Henry A. Cotton, "Some Problems in the Study of Heredity in Mental Diseases," *ibid*, LXIX (1912-13), 31 (this article contains a bibliography in psychiatry alone of nearly two hundred titles, almost all foreign and most of them German), and A. J. Rosanoff, "Dissimilar Heredity in Mental Disease," *ibid*, LXX (1913-14), 1.

¹⁴⁸ Solomon C. Fuller, "Alzheimer's Disease (Senium praecox) the Report of a Case and Review of All Published Cases," *J. Nerv. and Mental Dis.*, XXXIX (1912), Solomon C. Fuller and Henry I. Klopp, "Further Observations on Alzheimer's Disease," *Am. J. Insanity*, LXIX (1912-13), 17.

¹⁴⁹ LXVII (1910-11) and LXIX (1912-13).

¹⁵⁰ Sixty-third Annual Meeting of the American Medico-Psychological Association, May, 1907, Washington, D. C. Symposium on "Reception Hospitals, Psychopathic Wards, and Psychopathic Hospitals"—Drs. Adolf Meyer, Albert M. Barrett, Menas S. Gregory, Charles P. Bancroft. *Am. J. Insanity*, LXIV (1907-8), 182. Adolf Meyer, "Reception Hospitals, Psychopathic Wards and Psychopathic Hospitals," *ibid*, p. 221, C. P. Bancroft, "Reception Hospitals and Psychopathic Wards in State Hospitals for the Insane," *ibid*, LXV (1908-9), 57, M. S. Gregory, "Reception Hospitals, Psychopathic Wards and Psychopathic Hospitals," *ibid*, p. 63, J. Montgomery Mosher, "A Consideration of the Need of Better Provision for the Treatment of Mental Disease in Its Early Stage," *ibid*, p. 499, Campbell Meyers, "Neuropathic Wards in General Hospitals," *ibid*, p. 533, L. Vernon Briggs, "What Can Be Done for the Prevention of Insanity by the Treatment of Incipient Cases in General Hospitals, and What Has Been Done in the Past," *ibid*, LXVII (1910-11), 637.

¹⁵¹ Of the last-named the *American Journal of Insanity* said that "It should be ground for encouragement to members of the medical profession to learn that the recent movement to establish a psychiatric clinic at the Johns Hopkins Hospital owed its origin, not to the case of Harry Thaw, nor to the reading of the book entitled *A Mind That Found Itself*, nor to the organization of any society to promote the welfare of the insane, but to an educational campaign conducted by Dr. Stewart Paton, whereby the medical profession of the city became thoroughly informed as to the desirability of a psychopathic hospital." The *Journal* then mentions the appointment of Dr. Adolf Meyer as Professor of Psychiatry and Director of the Psychiatric Clinic of the Hospital, to take effect October, 1909. LXV (1908-9), 197.

ature, it should be added that a group of scientific papers was read at the opening exercises of the Phipps Clinic (April 16-18, 1913) which was subsequently published collectively in a Special Number of the *American Journal of Insanity* (LXIX, 835-1086)—a number of higher intellectual content, it would seem altogether probable, than any single number of the *Journal* issued before or since.¹⁵³

The opening of the Boston Psychopathic Hospital and of the Henry Phipps Psychiatric Clinic, within a year of each other, provided the most recent illustration of one of the forms, certainly one of the most important forms, taken by the growing development of social psychiatry—that psychiatry which no longer regarded the patient simply as a separate individual but also as a social unit.¹⁵³ Some years later (1919) Southard was to call this the outstanding development of the last quarter century of the American Medico-Psychological Association's history, "than which it might be hard to name a more important feature of the face of the world today."¹⁵⁴ The establishing of psychopathic hospitals was one of the most important manifestations of social psychiatry¹⁵⁵ for the reason that—to

¹⁵³ Its contents were the following: Stewart Paton, "The Psychiatric Clinic and the Community" (p. 841), Sir William Osler, "Specialism in the General Hospital" (p. 845); Adolf Meyer, "The Purpose of the Psychiatric Clinic" (p. 857), William McDougall, "The Sources and Direction of Psycho-Physical Energy" (p. 861), E. Bleuler, "Autistic Thinking" (p. 873), August Hoch, "Personality and Psychosis" (p. 887), Frederic Lyman Wells, "The Personal Factor in Association Reactions" (p. 897), F. W. Mott, "A Study of the Neuropathic Inheritance" (p. 907), O. Rossi, "On the Aetiology of Pellagra and Its Relation to Psychiatry" (p. 939); Harvey Cushing, "Psychic Disturbances Associated with Disorders of the Ductless Glands" (p. 965); Stewart Paton, "Primitive Mechanisms of Individual Adjustment" (p. 991), K. Heilbronner, "*Demenzprobleme*" (p. 997), Ernest Jones, "The Inter-relation of the Biogenetic Psychoses" (p. 1027); George H. Kirby, "Prognostic Principles in the Biogenetic Psychoses, with Special Reference to the Catatonic Syndrome" (p. 1035); Charles B. Dunlap, "Anatomical Borderline between the So-called Syphilitic and Metasyphilitic Disorders in the Brain and Spinal Cord" (p. 1045), Albert Moore Barrett, "Mental Disorders and Cerebral Lesions Associated with Pernicious Anemia" (p. 1063).

¹⁵³ William L. Russell, "The Widening Field of Practical Psychiatry," *ibid.*, LXX (1913-14), 459. Dr. Russell said further: "In New York, the State Charities Aid Association started after-care for the patients discharged from the State Hospitals of the metropolitan district, and carried it on until its value was demonstrated and it was taken over by the State. At present the Association is engaged in trying to demonstrate the usefulness of out-patient departments and social service work in dealing with mental disorder, with a hope that the State will eventually adopt them as definite features of its system."

¹⁵⁴ E. E. Southard, "Cross-Sections of Mental Hygiene 1844, 1869, 1894," Presidential Address at the 75th Annual Meeting of the Association, Philadelphia, June 1919, *ibid.*, LXXVI (1919-20), 91. Yet, Southard went on to say, "Social psychiatry is far from the whole of mental hygiene. For mental hygiene includes also the far more difficult and intriguing topic of the psychiatry of the individual, as related to himself and his organs and processes."

¹⁵⁵ By some, the term "mental hygiene" seems to be used as synonymous with "social psychiatry." In his Presidential Address of 1917, Wagner said that mental hygiene covered a

quote the Twelfth Annual Report of the Massachusetts State Board of Insanity¹⁵⁶—these hospitals were designed to “receive all classes of mental patients for first care, examination and observation, and provide short, intensive treatment of incipient, acute and curable insanity.” Further, the out-patient department of the psychopathic hospital “should afford free consultation to the poor, and such advice and medical treatment as would, with the aid of district nursing, promote the home care of mental patients”; and finally, “its social workers should facilitate early discharge and after-care of patients, and investigate their previous history, habits, home and working conditions, heredity and other causes of insanity, and endeavor to apply corrective and preventive measures.”¹⁵⁷ From the idea of medical social work, said Southard on the occasion of the seventy-fifth annual meeting of the Association,¹⁵⁸ it was “only a step to the development of psychiatric social work in Massachusetts, in 1912—a step stated by Richard Cabot himself to be the greatest innovation in medical social work since its foundation.” Not long afterward, in New York, the Governor authorized state hospital superintendents to establish at suitable locations out-patient departments, while “to further the social or domestic readjustment of mental patients, after-care or social-service work has been undertaken.”¹⁵⁹

Two further features characterized the psychiatric literature of this

wide field, “including the practical care and treatment of mental diseases and mental deficiency, and the application of psychiatric and psychological knowledge to social, industrial and economic problems” (*ibid.*, LXXIV, 1917-18, 1). Southard, as we have just seen, used “mental hygiene” as the only expression covering social psychiatry, on the one hand, and the psychiatry of the individual, on the other.

¹⁵⁶ James V. May, “The Functions of the Psychopathic Hospital,” *ibid.*, LXXVI (1919-20), 21.

¹⁵⁷ *Ibid.*, p. 22

¹⁵⁸ Southard, *ibid.*, LXXVI (1919-20), 108.

¹⁵⁹ William L. Russell, *ibid.*, LXX (1913-14), 459. See also C. Macfie Campbell, “The Role of the Psychiatric Dispensary a Review of the First Year’s Work of the Dispensary of the Phipps Psychiatric Clinic,” *ibid.*, LXXI (1914-15), 439; L. Vernon Briggs and A. Warren Stearns, “Recent Extension of Out-Patient Work in Massachusetts State Hospitals for the Insane and Feeble-Minded,” *ibid.*, LXXII (1915-16), 35; James V. May, “Some of the More Recent Problems Connected with the State Care of the Insane,” *ibid.*, p. 315; George M. Kline, “Social Service in the State Hospital,” *ibid.*, LXXIII (1916-17), 567; Arthur H. Harrington, “The Receiving Unit of the State Hospital at Howard, Rhode Island,” *ibid.*, LXXIV (1917-18), 635; Lawson Gentry Lowrey, “An Analysis of the Accuracy of Psychopathic Hospital Diagnoses,” *ibid.*, LXXV (1918-19), 351; James V. May, “The Functions of the Psychopathic Hospital,” *ibid.*, LXXVI (1919-20), 21; Lawson Gentry Lowrey, “A Study of the Diagnoses in Cases Seen at the Psychopathic Department and Hospital Department of the Boston State Hospital,” *ibid.*, LXXVII (1920-21), 437.

period.¹⁰⁰ One of these was the neuropathological work of Dr. E. E. Southard.¹⁰¹ The other was the emergence of Dr. William A. White as the exponent of what he labeled the genetic concept in psychiatry, and in particular as one of the earliest, as he was certainly the most prominent, to adopt a Freudian orientation toward psychiatric problems.

Dr. Southard found lesions in some 86 per cent of his series of dementia praecox cases; further, four groups of cases could be separated on the basis of focal atrophies and sclerosis in particular areas; and finally, it was those cases with postcentral and superior parietal lesions which showed catatonia. In 1916, he reported two further cases—cases of late catatonia showing focal lesions of the cortex of the left angular gyrus, “of course,” he said, “we mean by our title to suggest a genetic relationship between the focal lesions and the subjects’ symptoms. Yet we cannot offer proof of such relationship and are in one sense merely hoping to excite others to opposition or to similar reports.” Of these two cases, having their clinical onset at forty-one and thirty-six, respectively, one showed a cyst of softening and the other a solitary tubercle, and “it appears that both lesions may well be of a suitable age to correspond with the date of onset of the symptoms.” In any event, the isolated lesions in these cases were in the parietal region, “a region which has been stated in previous work from this laboratory to be correlated with catatonic symptoms.”¹⁰² (A clinical discussion of late catatonia, with a bibliography, was published by Dr. Strecker in the following year.¹⁰³) Earlier Southard had published, with Earl D. Bond, a

¹⁰⁰ That is, apart from the topic of general paresis, which, as the “paradigm of psychiatry,” is never absent from the literature. In 1914, at the seventieth annual meeting of the American Medico-Psychological Association, a symposium on general paralysis was held, consisting of the following papers (printed in *Am J Insanity*, LXXI, 1914-15): Thomas W. Salmon, “General Paralysis as a Public Health Problem” (p. 41), Adolf Meyer, “Differential Diagnosis of General Paresis” (p. 51), Charles B. Dunlap, “The Pathology of General Paralysis” (p. 249), Drew M. Wardner, “A Report of Five Cases of the Intracranial Injection of Auto-Sero-Salvarsan” (p. 459). Reference should also be made here to E. E. Southard and H. C. Solomon, *Neurosyphilis: Modern Systematic Diagnosis and Treatment Presented in One Hundred and Thirty-seven Case Histories* (Boston, W. M. Leonard, 1917).

¹⁰¹ I wonder whether any graduates of 74 Fenwood Road recall the motto that hung on the wall of Dr. Southard’s office: “’Tis strange that a harp of a thousand strings should stay in tune so long.” Perhaps some of us have since decided that the phrase “in tune” is an extremely relative one.

¹⁰² E. E. Southard, “A Study of the Dementia Praecox Group in the Light of Certain Cases Showing Anomalies or Scleroses in Particular Brain-Regions,” *Am J Insanity*, LXVII (1910-11), 118, and “On the Topographical Distribution of Cortex Lesions and Anomalies in Dementia Praecox, with Some Account of Their Functional Significance,” *ibid*, LXXI (1914-15), 383, 603. E. E. Southard and M. M. Canavan, “Focal Lesions of the Cortex of the Left Angular Gyrus in Two Cases of Late Catatonia,” *ibid*, LXXII (1915-16), 553.

¹⁰³ “Certain of the Clinical Aspects of ‘Late Katatonia,’ with a Report of Cases,” *ibid*, LXXIV (1917-18), 185.



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study of similar type on mental disease arising in the fifth decade.¹⁰⁴ As Director of the Boston Psychopathic Hospital, Southard became interested, from the standpoint of general practice and of psychopathic hospital practice, in the matter of early diagnosis, and out of practical considerations of this order developed what he termed a "Key to the Practical Grouping of Mental Diseases."¹⁰⁵ Its eleven groups he later compared with the twenty-two groups of the classification proposed by the Committee on Statistics of the American Medico-Psychological Association¹⁰⁶ and adopted by the Association—"in general a highly satisfactory classification . . . but in some respects not suitable to the somewhat broader material confronted by the general practitioners and by the staffs of psychopathic hospitals."¹⁰⁷

In 1907 Dr. William A. White published his *Outlines of Psychiatry*, No. 1 of The Nervous and Mental Disease Monograph Series founded in 1907 by Smith Ely Jelliffe and William A. White; in its first as in its fourteenth edition, White's book is the best "outline" of psychiatry, without question, in English. The year 1913 saw the appearance of the fourth edition of this work (there was a fifth edition two years later); it saw the founding, with Smith Ely Jelliffe, of the first periodical in English to be devoted to psychoanalysis¹⁰⁸—the *Psychoanalytic Review*, "a journal devoted to an understanding of human conduct"; and it saw the publication by Dr. White of a paper entitled "The Genetic Concept in Psychiatry,"¹⁰⁹ in which he said that it was necessary to understand how, since the mind has had a history, "there may be vestiges of that history preserved in the mind showing the sources of present-day structures. . . . The genetic concept must be reckoned with from now on." In 1916 appeared *Mechanisms of Character Formation*,¹⁷⁰ and, in the *Journal*, "Psychoanalytic Tenden-

¹⁰⁴ "Clinical and Anatomical Analysis of Twenty-Five Cases of Mental Disease Arising in the Fifth Decade, with Remarks on the Melancholia Question and Further Observations on the Distribution of Cortical Pigments," *ibid*, LXX (1913-14), 779. Also should be mentioned, as of the preceding year, "On the Somatic Sources of Somatic Delusions," *J Abnormal Psychol.*, VII (1912-13), 326.

¹⁰⁵ *J. Nerv. and Mental Dis*, XLVII (1918), 1.

¹⁰⁶ *Am. J. Insanity*, LXXIV (1917-18), 256.

¹⁰⁷ Southard, "Recent American Classifications of Mental Diseases," *ibid*, LXXV (1918-19), 331.

¹⁰⁸ Just as the *American Journal of Insanity* preceded the *Journal of Mental Science* as the first periodical in English to be devoted exclusively to psychiatry, so did the *Psychoanalytic Review*, in the field of psychoanalysis, enjoy a similar precedence over the *International Journal of Psychoanalysis* (founded 1920).

¹⁰⁹ *Am. J. Insanity*, LXX (1913-14), 441.

¹⁷⁰ Of which the *Journal* said that "like Hart's briefer volume, *The Psychology of Insanity*, it will be useful in disabusing minds of the notion that psychoanalysis consists of no more than far-fetched and doubtfully interpreted symbolisms," LXXIII (1916-17), 557.

cies,"¹⁷¹ of which Southard—saving Freud from his disciples—said that the meed of praise allotted to Freud by its author would be warranted only by some extraordinary discovery, such as the law of conservation of energy or the Darwinian principle; yet it was Southard who in his Presidential Address two years later so well brought out that "above all, psychiatry must be conceived to include the minor psychoses, the smallest diseases and the minutest defects of the mind."¹⁷² In 1916 and 1917 Dr. White discussed two papers presented before the Association by C. C. Wholey,¹⁷³ of the second of which he said that he did not know how a psychoanalytic paper got into the meeting, "but I want to congratulate the Association upon it. The fact is most encouraging." In 1917 also appeared *The Principles of Mental Hygiene*, and, with the joint authorship of Smith Ely Jelliffe, the second edition of the standard *Diseases of the Nervous System*.¹⁷⁴

Surveying American psychiatric literature of this period, at least as manifested in the "favorite" American textbooks of psychiatry,¹⁷⁵ Southard expressed himself as somewhat disappointed "to find so little actual theoretical controversy in American psychiatry." In examining these textbooks

with the aim of learning how many entities were considered by competent psychiatrists really to exist, I had anticipated most interesting divergences,

¹⁷¹ *Ibid.*, 599

¹⁷² Although it does not of course follow automatically from this that one regards Freud as the microscopist (versus the gross anatomist) of the psyche, as the psychoanalyst necessarily would

¹⁷³ C. C. Wholey, "A Psychosis Presenting Schizophrenic and Freudian Mechanisms with Schematic Clearness," *ibid.*, 583; also, "Revelations of the Unconscious in a Toxic (Alcoholic) Psychosis," *ibid.*, LXXIV (1917-18), 437.

¹⁷⁴ This was the period during which, in addition to the volumes and articles by William A. White with a psychoanalytic coloring, there began to appear the translations, most of them by A. A. Brill, of various works of Freud (and other psychoanalytic writers), such as: Freud, *Selected Papers on Hysteria* (1909); Freud, *Three Contributions to the Theory of Sexuality* (1910); Freud, *The Meaning of Dreams* (1913); Otto Rank, *The Myth of the Birth of the Hero* (1913); Karl Abraham, *Dreams and Myths* (1913); E. Hitschmann, *Freud's Theories of the Neuroses* (1913); Freud, *The Psychopathology of Everyday Life* (1914); Otto Rank and Hanns Sachs, *The Significance of Psychoanalysis for the Mental Sciences* (1915); Freud, *Leonardo da Vinci* (1916); Freud, *The History of the Psychoanalytic Movement* (1916); Freud, *Wit and Its Relation to the Unconscious* (1917); Freud, *Delusion and Dream* (1917); Freud, *Totem and Taboo* (1918); Freud, *Thoughts for the Times on War and Death* (1918); Freud, *Introductory Lectures on Psychoanalysis* (1920).

¹⁷⁵ Among these were De Fursac-Rosanoff, *Manual of Psychiatry* (4th ed., 1916); Francis X. Dercum, *A Clinical Manual of Mental Diseases* (2d ed., 1917); Knapp, in Strumpell's *Practice of Medicine*; Church and Peterson, *Nervous and Mental Diseases* (8th ed., 1914); William A. White, *Outlines of Psychiatry* (5th ed., 1915)

and hoped to learn something from the mutual critique which the various classifications would afford. . . . In point of fact, I found extraordinarily few genuine divergences The only sign of healthy competition in hypotheses is to be found in the Freudian discussions, which are certainly acrimonious enough, little as they frequently attack the central and underlying problems at stake. But, aside from the small Freudian unpleasantnesses, there is singularly little viable controversy over psychiatric theory in recent American work.¹⁷⁶

"Healthy competition in hypotheses" was to be forthcoming, however, over the succeeding years; the literature indicates fairly clearly certain of the broad lines along which this "competition" took place.

There was, for example, some further extension of the neuropathology

¹⁷⁶ E. E. Southard, *Am J Insanity*, LXXV (1918-19), 334. We cannot take leave of Dr. Southard (who died very prematurely in 1920) without quoting his estimate, certainly in Southardian vein, of Adolf Meyer's place and influence in American psychiatry: "I myself believe that no greater power to change our minds about the problems of psychiatry has been at work in the interior of the psychiatric profession in America than the personality of Adolf Meyer. If he will pardon me the phrase, I shall designate him as a ferment, an enzyme, a catalyzer. I don't know that we could abide two of him. But in our present status we must be glad there was one of him." "Presidential Address," *ibid*, LXXVI (1919-20), 107.

Fifteen and eighteen years after his death, the memory of Dr. Southard inspired an article in the *Journal* and a book, respectively: Leland B. Alford's "Dr. E. E. Southard's Scientific Contributions to Psychiatry, an Appreciation after Twenty Years," *Am J Psychiatry*, XCII (1935-36), 675, and Frederick P. Gay's *The Open Mind: Elmer Ernest Southard* (Chicago, Black Cat Press, 1938).

It may here be mentioned that within this period falls a criminal act similar to that of Czolgosz and of Guiteau, but differing in its nonfatal outcome and also in its psychiatric reverberations. I refer to the shooting, in Milwaukee, on October 14, 1912, of ex-President Theodore Roosevelt, by John Schrank, who had followed his intended victim about the country seeking a favorable opportunity to shoot him and who, when arrested, expressed the belief that Col. Roosevelt had guilty knowledge of President McKinley's death and that "*a man who wanted a third term had no right to live*" (italics the *Journal's*). (Curiously enough, many people have entertained very recently a belief practically identical with the second of these, so I am told, but unfortunately without giving rise to any suspicion of their sanity.) The *Journal* of the American Medical Association, in commenting upon the case in its issue of December 7, 1912, said: "The entire procedure is in gratifying contrast to some of our 'celebrated' murder trials, and is an unanswerable reply to the argument that such spectacles are necessary to protect individual rights or are unavoidable under our laws. It should be noted that the inquiry regarding Schrank's sanity was not a part of his trial for attempt to kill, or in any way a substitute therefor. Schrank has been declared insane by the court, and ordered confined to an asylum. . . . The plan avoids putting lunatics on trial on criminal charges, as the inquiry precedes the criminal trial. It also prevents the possibility of a short confinement in an asylum being substituted for a severer punishment, as has too often occurred. If Harry Thaw were adjudged sane, he would be a free man. If Schrank is at any time declared sane, he will still have to answer for his crime. We repeat, Wisconsin is to be congratulated on having such a law [Section 4700 of the revised statutes of Wisconsin, enacted in 1898] and such a judge." "Notes and Comment," *Am. J. Insanity*, LXIX (1912-13), 636.

logical research with which Southard was identified earlier, and perhaps more fully, than with his later interest in the psychopathic hospital movement, the early diagnosis of mental disorders especially of the more borderline variety, nosological classification from the standpoint of facilitating this type of diagnosis, psychiatric social work, and the general "mental hygiene" movement.¹⁷⁷ A paper published from Ann Arbor in 1920 presented dementia praecox "as a disease with special localization in the central nervous system causing degenerative changes which may be continuous but probably more frequently are intermittent, corresponding with improvement or remission of the clinical disease."¹⁷⁸ This description followed in the tradition of Alzheimer who, we are here reminded, reported in 1897 severe changes in the ganglion cells with a tendency to disorganization, much swelling of the nuclei of the nerve cells, and severe shrinking of the bodies of the ganglion cells; in his final report on the subject, in 1913, Alzheimer stated that "severe grade sclerosis of ganglion cells with fatty degeneration signifies severe injury to function." This same article of 1920 quotes Bleuler as saying in 1915: "Many think they are turning against me when they say physical changes lie at the bottom of dementia praecox. I myself have expressly emphasized this fact. One must acknowledge that at least the great majority of clinical pictures which are now collected under the name of dementia praecox rests on some toxic action or anatomical process which arises independently of psychic influences"; that cases arising from psychic causes exist "is yet to be proved, while the principal group in my opinion is certainly caused by organic changes."¹⁷⁹

In the same volume of the *Journal*, on the other hand, appeared a survey of the present status of the pathology of mental disorders,¹⁸⁰ the writer of which stated that

the pathology we see at the necropsy table and under the microscope does not carry us very far in the determination of the manner in which the operative factors act in the production of their effects upon the cortical substance

¹⁷⁷ Mention should here be made of the posthumously published work which Southard wrote in collaboration with Mary C. Jarrett, *The Kingdom of Evils: Psychiatric Social Work Presented in One Hundred Case Histories, Together with a Classification of Social Divisions of Evil* (New York, Macmillan, 1922)

¹⁷⁸ Adeline E. Gurd, "The Structural Brain Lesions of Dementia Praecox," *Am. J. Insanity*, LXXVII (1920-21), 201 (bibliography of 20 titles)

¹⁷⁹ Bleuler, *Zeitschr. f. d. ges. Neurol. u. Psychiat.*, XIII (1915), 450, quoted by Gurd.

¹⁸⁰ Albert C. Buckley, "The Present Status of the Pathology of Mental Disorders," *Am. J. Insanity*, LXXVII (1920-21), 395 (bibliography of 24 titles).

should we chance to know them . . . We are in much the same position with respect to the lack of an explanation for the pathology of mental disorders as the general pathologist is forced to occupy relative to the subject of the cancer problem. The general pathologist is familiar with the tissue changes in the various kinds of neoplasm, but of the actual forces at work in their production he can only surmise their origin

Thus we come to the work of Dr. Charles B. Dunlap (1863–1926), one of the most thorough, scrupulous, and rigorously scientific workers whom American psychiatry has known. In 1924 Dunlap reported his findings on a number of brains “better suited, we believe, for an anatomical study of dementia praecox than any heretofore used for this purpose,” adding that “we have rarely received a brain that met the conditions imposed, but we have selected eight cases out of a total of 31 received as coming somewhere *near* ideal conditions.”¹⁸¹ Above all, “we have considered control brain material, collected from so-called normal persons, without psychoses, to be absolutely necessary in this study.” Treatment and staining of all tissues, those from the eight cases of dementia praecox and those from the five controls, were “as nearly identical as we knew how to make them.” After discussing the findings of certain other workers and the possible explanation of them,¹⁸² Dunlap set forth his own findings in the following terms:

To establish a true organic basis for dementia praecox we believe requires the demonstration not so much of nerve-cell changes, our knowledge of which is painfully inadequate, as the demonstration of consistent changes in the brain *as a tissue*. . . . In “organic” reactions like those of general paralysis, senile and arteriosclerotic dementia, we do not find one element diseased and the rest healthy. Where one element is diseased the other elements react

¹⁸¹ “Dementia Praecox, Some Preliminary Observations on Brains from Carefully Selected Cases, and a Consideration of Certain Sources of Error,” *ibid.*, LXXX (1923–24), 403

¹⁸² For example “Alzheimer’s reports of loss of nerve cells in the outer layers of the cortex in the frontal lobes in dementia praecox have worried me considerably, for Alzheimer did not make careless statements, and his observations were always important. If Alzheimer worked *impressionistically* he could easily have believed that there was a loss of nerve cells in the outer layers of the frontal lobes in dementia praecox, for one may get a strong impression that such a loss exists when examining the shrunken dark staining cortex of some, not all, of our cases. Some of the smaller nerve cells in such cases may be so shrunken and so small that they could be overlooked as nerve cells, or taken for neuroglia cells, on cursory examination, the larger cells appear to stand out clearly with wide spaces separating them in such cases, and the general impression of cell loss is strong until corrected by close analysis with higher magnification. We believe the question of whether there is or is not actual nerve cell loss in the cortex of dementia praecox is one of the most fundamental of all questions in deciding whether or not this is an organic disease of the brain.” *Ibid.*, pp. 411, 412

also, and there is a general tissue alteration in which not only nerve cells but also neuroglia and blood vessels take part. We might reasonably expect, if this chronic condition called dementia praecox were an organic brain disease, to find likewise some sort of consistent tissue reaction, and not a nerve cell change exclusively. . . . I make a plea for reasonable *consistency* in findings, especially if far-reaching conclusions are to be based on them, and if we are to list dementia praecox among the organic brain diseases we must find, at least in a fair percentage of the cases, some kind of pathology that will hang together.

It would seem, judging by our findings, that dementia praecox is even less a structural brain disease than pellagra or alcoholism. In both of the latter conditions, changes, if present in the brain, are not primary but are secondary, not so much to varying somatic conditions as to fairly *specific* somatic conditions; but our study of dementia praecox, as far as it has gone, strongly indicates that it is a condition completely lacking in any fundamental or constant alteration of nerve cells, though dementia praecox shows at times within the brain the presence of nerve cell changes secondary to those varying somatic states of which we now have little knowledge, but which we find operating in so-called normal control cases. . . . I would not intimate that the nerve cell changes we have observed in dementia praecox are dependent on some definite or specific state of the body, or body organs, peculiar to this disorder. Our evidence does not reach thus far. We might better call any nerve cell alterations that may be seen in dementia praecox a reaction of the nerve cells to various, mostly unknown, somatic conditions (plus postmortem and technical factors) such as operate in the controls.

Since these nerve cell reactions in dementia praecox seem in no way specific and are not constant or uniform from case to case; since they do not differ materially in degree or in kind from the changes seen in the cells of control cases; we feel justified, at present, in believing that the changes are dependent on the same general causes that operate in the controls, and are not dependent on any special conditions existent in dementia praecox. In other words, the cell changes we have found do not seem to be related, either as cause or effect, to the disorder called dementia praecox. . . . We may say that our study so far of dementia praecox, in well-selected cases, has not shown even a suspicion of a consistent organic brain disease as a basis for the psychosis.¹⁸⁸

Simultaneously with this research, which produced what can reasonably be called one of the outstanding contributions to American psychiatric literature, various aspects of the psychological approach to the problem of mental disease were receiving attention. Representative of this trend were such discussions, to cite only some of those appearing

¹⁸⁸ See also Charles B. Dunlap, "The Pathology of the Brain in Schizophrenia," in *Schizophrenia (Dementia Praecox)*, (New York, Association for Research in Nervous and Mental Disease, 1928), p. 371.

in the *Journal*, as Phyllis Greenacre's "The Content of the Schizophrenic Characteristics Occurring in Affective Disorders,"¹⁸⁴ William A. White's "Some Considerations Bearing upon the Diagnosis and Treatment of Dementia Praecox,"¹⁸⁵ William McDougal's "The Nature of Functional Disease,"¹⁸⁶ Adolf Meyer's "Constructive Formulation of Schizophrenia,"¹⁸⁷ Edward A. Strecker's "A Preliminary Study of the Precipitating Situation of Two Hundred Cases of Mental Disease"¹⁸⁸ and, with G. F. Willey, "An Analysis of Recoverable 'Dementia Praecox' Reactions,"¹⁸⁹ and George S. Amsden's "The Practical Value of the Study of Personality in Mental Disorders."¹⁹⁰ It should also be noted that in 1920 a distinctly remarkable volume by Edward J. Kempf appeared, entitled *Psychopathology*. Based on observations carried out at St. Elizabeths Hospital, and supplemented by exhaustive case histories, it was the first application, certainly on anything like so extensive a scale, of psychoanalytic concepts to the field of the psychoses. It was one of the conclusions of the author that psychoses differ from normal behavior chiefly in degree; it was his belief, at all events, that "In the psychoses the conflict is far more severe than normal, due to the vigor of the segment [that is, of the instinctual drive or drives in question] or the weakness of the ego."¹⁹¹

The year 1925 saw the publication of a volume as different from this as possible, the *Problems of Personality; Studies Presented to Dr. Morton*

¹⁸⁴ *Am J Insanity*, LXXV (1918-19), 197

¹⁸⁵ *Ibid.* (renamed the *American Journal of Psychiatry*), LXXVIII (1921-22), 193

¹⁸⁶ *Ibid.*, p. 335

¹⁸⁷ *Ibid.*, p. 355.

¹⁸⁸ *Ibid.*, p. 503

¹⁸⁹ *Ibid.*, LXXX (1923-24), 593

¹⁹⁰ *Ibid.*, LXXIX (1922-23), 501.

¹⁹¹ The work in question, clearly, is based as squarely as possible on that of Freud (to which source of inspiration the author seems to have given rather little credit). I should not feel justified in saying that the chief claim to originality on the part of the author of this book lay in terminology, yet there is, clearly enough, a definite parallelism between certain conceptions of Kempf's and the corresponding ones of Freud. Kempf states that feelings and desires, or affective cravings, are constituted by sensory streams flowing from the periphery of different segments of the autonomic apparatus, and are due to, and associated with, an uncomfortable autonomic tension which seeks relief through appropriate action of the projicent apparatus (the neuromuscular system). According to Freud, the "instinct" is the psychic representative of a continuously active stimulus originating in the interior of the body and flowing into the psyche from the somatic field—a region of the body which is able to send stimuli to the psyche being referred to as an "erotogenic zone." It still remains an outstanding merit of Kempf's *Psychopathology* to have seen the applicability of Freudian mechanisms and symbolisms to psychotic case material in a degree and on a scale previously unattempted in American psychiatry.

Prince, Pioneer in American Psychopathology, edited by Dr. C. Macfie Campbell and others; this volume comprised a collection of some twenty-four essays, by both American and English authors, of extremely wide scope in their treatment of very varied aspects of psychopathology. In the same year, Dr. William A. White, in his Presidential Address before the American Psychiatric Association, came out boldly with the statement that "since the advent of psychoanalysis we for the first time . . . have our interest centered upon the actual mechanisms that are producing the symptoms"—that is, the mechanisms of which the symptoms are the expression, as Kempf had so thoroughly demonstrated on clinical material of the kind to which White was chiefly referring. White added that "We understand that the deflection of our vision to the body or to the infectious organism is but an example of that mechanism of projection with which we have become so familiar, and that it was because of the emotional necessity for seeing causes elsewhere than in ourselves that we for so many centuries have been unable to face the facts of our own mental life."¹⁰²

There now began to be set in motion a trend in the direction of investigating the physical or somatic concomitants, in various respects, of mental disease. Under such a heading could perhaps be listed the activities of Dr. Henry A. Cotton, whose researches convinced him that focal infection played a very considerable part in the etiology of mental disorder.¹⁰³ Unfortunately for the rosy therapeutic vistas which this conception seemed to open up, a prolonged and painstaking investigation carried out by the staff of the New York Psychiatric Institute failed to substantiate the claims which Dr. Cotton had made, and seemed to indicate, in addition, that the methods used by Dr. Cotton for establishing focal infection were, at least in respect of certain loci, unsatisfactory.¹⁰⁴

At about this same time Theophile Raphael carried out a number of studies on the physiologic level in dementia praecox, in line with the

¹⁰² William A. White, "Presidential Address" before the 81st annual meeting of the American Psychiatric Association, May, 1925 *Am. J. Psychiatry*, LXXXII (1925-26), 1.

¹⁰³ Henry A. Cotton, *The Defective Delinquent and Insane. the Relation of Focal Infections to Their Causation, Treatment and Prevention* (Princeton, Princeton Univ. Press, 1921); Henry A. Cotton, "The Etiology and Treatment of the So-called Functional Psychoses: Summary of Results Based upon the Experience of Four Years," *Am. J. Psychiatry*, LXXIX (1922-23), 157.

¹⁰⁴ Nicholas Kopeloff and Clarence O. Cheney, "Studies in Focal Infection: Its Presence and Elimination in the Functional Psychoses," *Am. J. Psychiatry*, LXXIX (1922-23), 139; Nicholas Kopeloff and George H. Kirby, "Focal Infection and Mental Disease," *ibid.*, LXXX (1923-24), 149.

cyanosis of the hands and other outward evidences of vegetative imbalance manifested by a proportion of cases of dementia praecox, to which Kraepelin among others had called attention. In these and similar findings, no less than in the anatomic field, the matter of physical or psychic primacy "is of interest, but as yet more or less obscure, although, inferentially, one might postulate a certain somatic vulnerability as regards the endocrino-autonomic field, which, under the stress operative upon the psychic level, may become clinically manifest as described." From these and other studies Raphael concluded that "there occurs in dementia praecox, with essential consistency, a definite hypo-oxidative status, physiologically, with general metabolic depression and associated with vegetative features, most marked in the acute, unadjusted or exacerbative phases, and by that token probably reactionary or associative, although, no doubt, frequently superimposed upon a structure initially vulnerable."¹⁹⁵

A not altogether dissimilar approach was utilized by Charles E. Gibbs who, in a series of studies,¹⁹⁶ showed for example that in one hundred and seven female patients with recovery from two or more manic-depressive attacks, masculine pubic hair and mammary hair occurred with much less frequency than in those with dementia praecox, and with only a slightly greater frequency than in nonpsychotic pregnant women; also that in many patients with dementia praecox the blood cholesterol (as "a measure of the fundamental process on which the functional metabolism of brain and sex directly depend") is unusually low, and "may be more directly correlated with the psychosis and with sex than with any other recognized factors."

Stimulated by "a growing interest in a possible connection between endocrine organs and psychoses," and by the fact, also, that in respect of dementia praecox F. W. Mott in London and N. D. C. Lewis in Washington had formulated theories "which assume an intimate connection between anatomic findings in the endocrine organs and the psychosis," Bertram D. Lewin examined histologically the hypophysis, the thyroid

¹⁹⁵ Theophile Raphael, "The Physiologic Level in Dementia Praecox," *ibid.*, LXXIX (1922-23), 515

¹⁹⁶ "Sex Development and Behavior in Male Patients with Dementia Praecox," *Arch. Neurol. and Psychiatry*, IX (1923), 73, "Sex Development and Behavior in Female Patients with Dementia Praecox," *ibid.*, XI (1924), 179; "Sexual Behavior and Secondary Sexual Hair in Female Patients with Manic-Depressive Psychoses, and the Relation of These Factors to Dementia Praecox," *Am. J. Psychiatry*, LXXXI (1924-25), 41; "The Supra-renal Cortex and Blood Cholesterol in Dementia Praecox," *ibid.*, LXXXII (1925-26), 189

gland, the adrenal glands, and the sex glands in unselected psychotic material. He stated that, while emphasizing that "we do not mean to assert the absence of any possible relation between endocrine organs and psychosis in those groups, such as dementia praecox, where our findings were essentially negative, we do, however, feel that there is no evidence in our material of such anatomic-psychiatric correlation, and for the dementia praecox group in particular we believe that our material was quite comparable to the material on which several, in our opinion, untenable hypotheses have been based."¹⁹⁷

It was at this point that the influence of Kretschmer's *Körperbau und Charakter*, and particularly of the correlation to which he pointed between physical habitus and type of psychosis, began to make itself felt in the form, initially in American psychiatric literature, of F. I. Wertheimer and Florence E. Hesketh's "Observations and Remarks on the Physical Constitution of Female Psychiatric Patients"¹⁹⁸ and in the same authors' *The Significance of the Physical Constitution in Mental Disease* (1926). In the latter the authors call attention to the interesting point that Esquirol compiled statistics regarding the external appearance of his patients, of whom he said, anticipating Kretschmer by exactly one hundred years, that "when persons of the lymphatic or phlegmatic temperament, or those who have a pale exsanguinous constitution, fall into mania or monomania, their disorder is more liable than that which occurs in other constitutions to pass into dementia or incoherence." In addition to this initial elaboration of Kretschmer's formulations, mention should be made also of Herman M. Adler and George J. Mohr's "Some Considerations of the Significance of Physical Constitution in Relation to Mental Disorder."¹⁹⁹

Before turning to certain other developments of American psychiatry dating from this time, a brief backward look may be taken, through the medium of the Presidential Address delivered by Dr. Adolf Meyer in 1928: "Thirty-Five Years of Psychiatry in the United States, and Our Present Outlook." The thirty-five years, dating from 1893, referred to the period of his own activity in American psychiatry, of which the general evolution seems to have been:

First, humanitarian work in the institutions for the insane, and legal preoccupations about insanity for the protection of patients and public, then a study

¹⁹⁷ Bertram D. Lewin, "A Study of the Endocrine Organs in the Psychoses, *Am. J. Psychiatry*, LXXXIV (1927-28), 391.

¹⁹⁸ *Ibid.*, LXXXIII (1926-27), 499

¹⁹⁹ *Ibid.*, LXXXIV (1927-28), 701

of what it all *might* be in the light of the old contrast of physical *vs.* mental disease; then we find the appeal to cell-biology and correlation of sciences; more and more a study of the plain facts of the history and the reactions of the patient and of habit-organization and disorganization (or, to use the latest scientific slang, "conditioning" and "fixation"), the combination of mass treatment and individual treatment, and with it all the cultivation and conception of a psychopathology; first perhaps as more or less critical common sense; then a more erudite and specialized system of hypotheses, that which grew around the experiences and concepts of hypnotism and hysteria and later katharsis and resistance and repression and release and various developments of a Freudian nature; simultaneously the development of Kraepelinian nosology, and on the other hand the singling out of constitutional types and reaction sets, with confidence in a background of biological and normal everyday critical common sense.²⁰⁰

Six years later, in his Presidential Address of 1934, Dr. George H. Kirby was to survey nearly the same thirty-five years—a period, he said, which had witnessed two noteworthy advances in the domain of psychiatry.

The first event to which I refer as marking a major step in the progress of psychiatry was the discovery in 1913 by Moore and Noguchi of the spirochaete *pallida* as the cause of general paralysis. The second event marking a great forward step in psychiatry was not, like the first, a clear-cut discovery, but a conception of slow growth built upon empirical observation. . . . I refer to the gradual emergence of the conception that psychic or emotional causes can produce not only mental illness, but that these causes are also capable of producing a great variety of functional disturbances and physical symptoms . . . We call this the "psychogenic concept" in medicine.²⁰¹

In an article published in the preceding year (1933), we find also a retrospect—one less panoramic, and having a more immediate bearing upon American psychiatric literature. J. C. Whitehorn and Gregory Zilboorg's "Present Trends in American Psychiatric Research."²⁰² This article presented a survey of the type of scientific articles published in the *American Journal of Psychiatry*, the *Archives of Neurology and Psychiatry*, and the *Journal of Nervous and Mental Disease* during the preceding decade. The authors divided these papers into the five groups, roughly, of clinical studies, studies more specifically psychological; physiological studies (including a few on anatomical subjects); studies of the

²⁰⁰ *Ibid.*, LXXXV (1928-29), 1.

²⁰¹ George H. Kirby, "Presidential Address Modern Psychiatry and Mental Healing," *ibid.*, XCI (1934-35), 1

²⁰² *Am J Psychiatry*, XC (1933-34), 303.

relations of psychiatry to general medicine, sociology, economics, law, etc.; and a miscellaneous group. Three of these groups showed a slight decrease in the five years 1926-1930 as compared with the five years 1921-1925, but the other two groups showed a marked increase; for the physiological studies rose from a total of 247 pages published in the first half of the decade in question to 404 pages published in the second half, while the psychological studies showed the even greater difference of 817 pages and 1923 pages.

Of recent years two fundamentally new trends have become crystallized in clinical psychiatry: first, is that under totality we understand not only the sum total of obvious factors (external, physical, social, physiological, etc.), and their interrelations, but also, if not primarily, the deeper unconscious attitudes, assets and liabilities. The emphasis on the consideration of the total personality would lack its most significant value if the unconscious life of the individual were not included. . . The second trend in present-day clinical psychiatry is of no less importance; it is expressed in the principle that normal psychology has become more and more a subject of interest to the psychiatrist. As a matter of fact, the modern psychiatrist, intending as he does to deal with the totality of the individual's reactions, centers his attention on these reactions, and not on what is specifically pathological. Adolf Meyer's constant reminder that a given psychopathological unit is an *experiment of nature* serves as a stimulus for the increased interest in the psychology of the so-called normal individual. The psychobiological concepts of Meyer and the psychodynamic concepts of Freud did much to develop psychiatric interest in the individual as a functional unit regardless of the given mental pathology. This interest in normal psychology is far from being an academic interest only, for the comparative study of this normal psychology might open new avenues for practical work and shed important light on psychiatric problems of vital importance.

This analysis of the American psychiatric literature of the ten years 1921-1930, and the trends in American psychiatry which it reflected, was published on the very eve, as it happens, of a period (roughly, the final decade of one hundred years of American psychiatric literature) marked by the introduction of a number of new therapeutic techniques and by the consequent shifting of interest, in large measure, to the exploitation of these techniques and to studies more or less directly stimulated by these therapeutic procedures. Before indicating more specifically the various manifestations of a trend of such breadth and generality, however, brief mention should be made of an innovation in the diagnostic

rather than in the therapeutic field, introduced into American psychiatric literature in 1924,²⁰³ three years after its original publication abroad.²⁰⁴ I refer to the Rorschach test as a "diagnosis of personality in both the intellectual and affective functionings."²⁰⁵

As belonging also to this general period we must mention, not the origin of child guidance clinics, which dates back to 1909 (with their original function an attack upon such problems as delinquency), but the development of the child guidance clinic, particularly as this took place under the demonstration project sponsored by the Commonwealth Fund, of which the twofold function was therapy and prevention. A full account of this development, from its beginnings, is excellently set forth in Dr. George S. Stevenson and Geddes Smith's *Child Guidance Clinics, a Quarter Century of Development*.²⁰⁶ There is also Dr. Lawson G. Lowrey and Geddes Smith's *The Institute for Child Guidance, 1927-1933*,²⁰⁷ covering the first six years of the existence of the Institute, during which it trained 50 psychiatrists and 289 psychiatric social workers, and gave clinical service to more than 2,600 cases. Of the large body of contributions emanating from the considerable number of child guidance clinics which became established throughout the country, the greater number were published in *Mental Hygiene* and, in particular, in the *American Journal of Orthopsychiatry*, founded in 1930, under the editorship of Dr. Lawson G. Lowrey, as the organ of the American Orthopsychiatric

²⁰³ H. Rorschach and E. Oberholzer, "The Application of the Interpretation of Form to Psychoanalysis," *J Nerv and Mental Dis*, LXIX (1924), 225, 359.

²⁰⁴ H. Rorschach, *Psychodiagnostik, Methodik und Ergebnisse eines wahrnehmungsdiagnostischen Experiments (Deutenlassen von Zufallsformen)*, (Bern and Leipzig, E. Bircher, 1921).

²⁰⁵ Some of the representative articles on the Rorschach test are the following: Samuel J. Beck, "The Rorschach Test and Personality Diagnosis," *Am J Psychiatry*, LXXXVII (1930-31), 19, and "The Rorschach Method and Personality Organization," *ibid*, XC (1933-34), 519 (bibliography of 11 titles). W. Line and J. D. M. Griffin, "Some Results Obtained with the Rorschach Test, Objectively Scored," *ibid*., XCII (1935-36), 109. A. W. Hackfield, "An Objective Interpretation by Means of the Rorschach Test of the Psychobiological Structure Underlying Schizophrenia, Essential Hypertension, Graves' Syndrome, etc.," *ibid*, XCII (1935-36), 575. John D. Benjamin and Franklin G. Ebaugh, "The Diagnostic Validity of the Rorschach Test," *ibid*, XCIV (1937-38), 1163 (bibliography of 7 titles). Samuel J. Beck, *Introduction to the Rorschach Method: A Manual of Personality Study* (Monograph No. 1 of the American Orthopsychiatric Association, Menasha, Wisconsin, 1937). Samuel J. Beck, *Personality Structure in Schizophrenia* (Nervous and Mental Disease Monographs, No. 63, New York, 1938) (The application of the Rorschach test to 81 patients and 64 controls). Douglas McG. Kelley and S. Eugene Barrera, "Rorschach Studies in Acute Experimental Alcoholic Intoxication," *Am J Psychiatry*, XCVII (1940-41), 1341 (bibliography of 15 titles).

²⁰⁶ New York, Commonwealth Fund, 1934.

²⁰⁷ New York, Commonwealth Fund, 1933.

Association.²⁰⁸ Although it would be invidious to single out one individual worker in the field of child psychiatry to the exclusion of various others who have made valuable contributions in this field, reference should nevertheless be made to Dr. David M. Levy. His work, for example, on maternal overprotection and on "affect hunger"—meaning "an emotional hunger for maternal love and those other feelings of protection and care implied in the mother-child relationship"—has been among the outstanding contributions to the study of child psychiatry.²⁰⁹ A feature of the Ninety-third Annual Meeting of the American Psychiatric Association, in 1937, was a symposium on child psychiatry.²¹⁰

During the fifteen years from 1927 to 1942 there appeared in the *American Journal of Psychiatry* a larger number of articles on the subject of epilepsy, clinical and experimental, than on any other single subject with the exception of schizophrenia. In Volumes LXXXIV to XCVIII, inclusive, of the *Journal*, there were published some sixty-three articles on various aspects of epilepsy and the convulsive state, almost two thirds of which, however, were concentrated within five years, since eighteen papers appeared in Volumes LXXXVII and LXXXVIII (1930-31 and 1931-32) and twenty-one in Volumes XCV, XCVI, and XCVIII (1938-39, 1939-40, and 1941-42). This period of increased productivity in the study of the epileptic disorders—a productivity paralleled elsewhere in the fact that it was largely stimulated by the introduction of new methods of therapy: dehydration, the ketogenic diet, sodium diphenyl hydantoinate (dilantin), for example—was ushered in, in at any rate a chronological sense, by the thoughtful paper by Dr. William T. Shanahan, Superintendent of Craig Colony, on the convulsive phenomenon *per se*, "Convulsions in Infancy and Their Relationship, If Any, to a Subsequent Epilepsy,"²¹¹ and by William G. Lennox and Stanley Cobb's comprehensive monograph *Epilepsy*²¹² and Fritz B. Talbot's *Treatment of*

²⁰⁸ As we have *orthopedics*, referring, literally, to "straightening children," so we have orthopsychiatry, or "straightening psychiatry."

²⁰⁹ This work is embodied in the volume *Maternal Overprotection* (New York, Columbia Univ. Press, 1943).

²¹⁰ *Am. J. Psychiatry*, XCIV (1937-38), 643-708.

²¹¹ *Ibid.*, LXXXIV (1927-28), 591. It is of a certain interest to compare Shanahan's clinically based and earlier statement that "any person may at some time of life have some sort of an epileptiform reaction" with Freud's opinion (1929) that the epileptic reaction is organically prepared in all human beings. See also an article of fifteen years later on a similar subject. Douglas A. Thom, "Convulsions of Early Life and Their Relation to the Chronic Convulsive Disorders and Mental Defect," *ibid.*, XCVIII (1941-42), 574.

²¹² Baltimore, Williams & Wilkins, 1928.

Epilepsy.²¹³ Without attempting, as is neither necessary nor desirable, to survey the more than sixty-five articles on the convulsive disorders which have been published in the *American Journal of Psychiatry* alone since 1927, reference may be made to seven of these as among the more representative, from one standpoint or another, of the work done in this field, namely, the papers by S. Bernard Wortis (1932), Calvert Stein (1933), Brown and Paskind (1937), Helmholtz and Goldstein (1938), Paskind and Brown (1939), Goldstein and McFarland (1940), and Dickerson (1942).²¹⁴ To these should perhaps be added two articles on narcolepsy;²¹⁵ and also, of course, the volume of the Association for Research in Nervous and Mental Disease on *Epilepsy and the Convulsive State*,²¹⁶ and the section on "Electrophysiology and Epilepsy" and on "Electroencephalography and Epilepsy," by William G. Eennox, in the "Review of Psychiatric Progress 1941" and the "Review of Psychiatric Progress 1942."²¹⁷

From the year 1918 dates one of the outstanding therapeutic triumphs which psychiatry can claim, for in that year Wagner von Jauregg, who had for some nine years worked with various foreign proteins to the same end, published in the *Psychiatrisch-neurologische Wochenschrift* a report on the effect of malaria upon general paralysis. This work was taken up in this country in late 1922 at St. Elizabeths Hospital in Washington, and in early 1923 at the New York Psychiatric Institute. From the former came in 1924 the first report in American psychiatric literature on the malaria treatment of general paralysis, the authors of which obtained a "good remission" in 30 per cent of cases treated.²¹⁸ These results were in

²¹³ New York, Macmillan, 1930

²¹⁴ S. Bernard Wortis, "Experimental Convulsions," *ibid*, LXXXVIII (1931-32), 611 (bibliography of 22 titles), Calvert Stein, "Heredity Factors in Epilepsy," *ibid*, LXXXIX (1932-33), 989 (bibliography of 39 titles), Meyer Brown and Meyer Paskind, "A Review of Physico-Chemical Studies in Epilepsy," *ibid*, XCIII (1936-37), 1009 (bibliography of 61 titles); Henry F. Helmholtz and Moe Goldstein, "Results of 15 Years' Experience with the Ketogenic Diet in the Treatment of Epilepsy in Children," *ibid*, XCIV (1937-38), 1205, Harry Paskind and Meyer Brown, "Constitutional Differences between Deteriorated and Non-Deteriorated Patients with Epilepsy," *ibid*, XCV (1938-39), 901 (bibliography of 40 titles), H. Goldstein and R. A. McFarland, "The Biochemistry of Epilepsy: a Review," *ibid*, XCVI (1939-40), 771 (bibliography of 197 titles), Willard W. Dickerson, "The Present Status of Dilantin Therapy," *ibid*, XCVIII (1941-42), 515 (bibliography of 44 titles)

²¹⁵ S. Bernard Wortis and Foster Kennedy, "Narcolepsy," *ibid*, LXXXIX (1932-33), 939 (bibliography of 40 titles). J. Notkin and Smith Ely Jelliffe, "The Narcolepsies," *ibid*, XC (1933-34), 733 (bibliography of 18 titles)

²¹⁶ New York, 1929

²¹⁷ *Am. J. Psychiatry*, XCVIII (1941-42), 592 (bibliography of 35 titles), and XCIX (1942-43), 604 (bibliography of 55 titles).

²¹⁸ Nolan D. C. Lewis, Lois D. Hubbard, and Edna G. Dyar, "The Malarial Treatment of Paretic Neurosyphilis," *ibid*, LXXXI (1924-25), 175.

close agreement with the composite results available some five years later, namely, that of 2,460 malaria-treated cases of general paralysis collected from the literature, a full remission occurred in about 27 per cent, with the production of an incomplete remission in an additional 26 per cent.²¹⁹ The therapeutic outcome was somewhat less favorable than this, on the other hand, in two of the largest series reported by individual observers: Hinsie and Blalock, writing in 1931 of 197 cases treated in the period 1923-1926, reported a remission rate, as of the date of writing, of 22 per cent;²²⁰ and Matthews, Bookhammer, and Izlar, writing in 1938 of 511 cases treated between 1930 and 1934, reported a remission in 13 per cent of the patients treated.²²¹ In the largest total of malaria-treated cases of general paralysis, 8,038 in number, 26 per cent were stated as able to resume their former occupation, 22 per cent as improved, 28 per cent as unimproved, and 23 per cent as dead since the induction of malaria.²²²

Subsequently, electropyrexia replaced to some extent the pyrexia produced by the plasmodium of tertian malaria in the treatment of general paralysis,²²³ although without noticeable advantage from the standpoint of therapeutic result,²²⁴ according to Hinsie and Blalock's comprehensive survey of the subject.

A second innovation in the treatment of general paralysis, this time of American origin, was introduced practically simultaneously with the malaria treatment, in the form of tryparsamide, a highly soluble arsenical; the first report on its use appeared in 1923.²²⁵ Six years later it was possible to collect from the literature (none of it published in the *Journal*) 542 tryparsamide-treated cases of general paralysis, in about 35 per cent of which full remission of mental symptoms occurred.²²⁶ Both

²¹⁹ Henry A. Bunker, "Recent Methods in the Treatment of General Paralysis. a Brief Survey," *ibid*, LXXXV (1928-29), 681.

²²⁰ Leland E. Hinsie and Joseph R. Blalock, "Treatment of General Paralysis Results in 197 Cases Treated from 1923-1926," *ibid.*, LXXXVIII (1931-32), 541.

²²¹ Robert A. Matthews, Robert S. Bookhammer, and William H. Izlar, "Paresis an Analysis of Five Hundred and Eleven Treated Cases," *ibid*, XCIV (1937-38), 1259.

²²² R. A. Vonderlehr, *Malaria Treatment of Parenchymatous Syphilis of the Central Nervous System* (Supplement No. 107 to Public Health Reports, Washington, D. C., 1933).

²²³ Clarence A. Neymann, "The Effect of Artificial Fever on the Clinical Manifestations of Syphilis and the Treponema Pallidum," *Am. J. Psychiatry*, XCIII (1936-37), 517 (bibliography of 42 titles).

²²⁴ Leland E. Hinsie and Joseph R. Blalock, *Electropyrexia in General Paralysis* (Utica, State Hospitals Press, 1934).

²²⁵ W. F. Lorenz, A. S. Loevenhart, W. J. Bleckwenn, and F. J. Hodges, "The Therapeutic Use of Tryparsamide in Neurosyphilis," *J. Am. Med. Assn*, LXXX (1923), 1497.

²²⁶ Henry A. Bunker, *Am. J. Psychiatry*, LXXXV (1928-29), 681. For further references (up to 1927) see S. I. Schwab and L. D. Cady, "The Use of Tryparsamide in Neurosyphilis," *Am. J. Syph., Gon., and Ven. Dis.*, XI (1927), 1.

these methods of treatment of general paralysis have stood the test of time, and indeed the general tendency has been to employ a combination of fever therapy and chemotherapy, with various subsequent modifications of both, such as in the substitution of mechanically induced for malaria-induced fever, for example, and in the use of newer arsenicals (such as aldarsoné).²²⁷

Just as the 1930-31 volume of the *Journal* was characterized by a rather sudden accession of articles on the epileptic disorders, so the same was true of the volume of the following year with regard to schizophrenia, eight articles on schizophrenia appeared in the 1931-32 volume. In 1931, also, was published Volume X of the Association for Research in Nervous and Mental Disease, on *Schizophrenia (Dementia Praecox); an Investigation of the Most Recent Advances, as Reported by the Association for Research in Nervous and Mental Disease*.²²⁸ But the comparison in this respect between the epileptic disorders and schizophrenia ceases here; for the number of articles on the latter subject contributed to the *Journal* during the ensuing fifteen-year period was almost exactly double the number on the former (although this still leaves the subject of the convulsive states with a very respectable degree of interest manifested in it in the pages of the *Journal*). But more than this, the number of contributions to the study of schizophrenia, beginning in particular with the introduction of "shock therapy" by Sakel in 1937, rose in a crescendo to an average of twenty-five articles a year published in the *Journal* alone during the four years 1938 to 1941, inclusive. It is particularly fitting, perhaps, that this renascence of interest in schizophrenia dating from 1931 should have been preluded, so to speak, by an essay (published in the *Journal* in 1930) by Bleuler, on "The Physiogenic and Psychogenic in Schizophrenia."²²⁹ And reference should not be omitted to one of the more important papers in the American literature of schizophrenia, which was published in 1929: Gregory Zilboorg's

²²⁷ See, for example, B. Dattner and E. W. Thomas, "The Management of Neurosyphilis," *Am J Syph, Gon, and Ven Dis*, XXVI (1942), 21, H. W. Kendall, W. M. Simpson, and D. L. Rose, "The Treatment of Neurosyphilis by Artificial Feverchemotherapy," *Arch Phys Therap*, XXIII (1942), 517, A. Marn, "Combined Artificial Fever, Chemotherapy, and Vaccinotherapy in the Treatment of Neurosyphilis," *Am J Syph, Gon, and Ven Dis*, XXVI (1942), 234, Jack R. Ewalt, Ernest H. Parsons, Stafford L. Warren, and Stafford L. Osborne, *Fever Therapy Technique* (New York, Harpers, 1939).

²²⁸ This was preceded, in 1928, by Volume V of the Association for Research in Nervous and Mental Disease, also entitled *Schizophrenia (Dementia Praecox)*.

²²⁹ *Am J Psychiatry*, LXXXVII (1930-31), 203. Abstract, made by Dr. Manfred Bleuler, of an address before the Massachusetts Psychiatric Society, Dec. 7, 1929.

"The Dynamics of Schizophrenic Reactions Related to Pregnancy and Childbirth."²³⁰

In 1934 the Scottish Rite Masons of the Northern Jurisdiction resolved to support a research into the cause of dementia praecox. The first step taken to give effect to this resolution was to make a preliminary survey of the field. Undertaken by Dr. Nolan D. C. Lewis, then of St. Elizabeths Hospital, the results of this survey were embodied in a volume published in 1936, entitled *Research in Dementia Praecox (Past Attainments, Present Trends and Future Possibilities)*²³¹—a volume which if for nothing else would be noteworthy for the exhaustive bibliographies which it includes. In spite of the fact that this book covers, especially bibliographically, the entire field in question up to the year 1936, mention should be made in passing of two articles (among the more than a dozen that might be cited) that were published in 1934. One of these is Jacob H. Conn's historically and philosophically oriented "Examination of the Clinico-pathological Evidence Offered for the Concept of Dementia Praecox as a Specific Disease Entity."²³² The other is cited because of its bearing on the subject of heredity in mental disorders, with special reference to the phenomenon of mental disorder in twins: Aaron J. Rosanoff's "The Etiology of So-called Schizophrenic Psychoses, with Special Reference to Their Occurrence in Twins"—a discussion of 142 pairs of twins, out of a total of 1,014 pairs with mental disorders, which represented cases of "dementia praecox" or "schizophrenia" in one or both twins of each pair.²³³ As an inclusive survey of one aspect of the study of schizophrenia, a third article, of later date, should here be included: R. A. McFarland and H. Goldstein's "The Biochemistry of Dementia Praecox; a Review."²³⁴

In 1937 Dr. Manfred Sakel described for the first time in English (thanks to the translation of Dr. Joseph Wortis) "A New Treatment of Schizophrenia."²³⁵ This treatment had its origins in the effort to alleviate withdrawal symptoms in morphine addicts, to whom were administered doses of insulin "just large enough to pacify patients who grew excited

²³⁰ *Ibid.*, LXXXV (1928-29), 733 (bibliography of 82 titles)

²³¹ Published by the National Committee for Mental Hygiene, New York.

²³² *Am. J. Psychiatry*, XC (1933-34), 1039 (bibliography of 50 titles)

²³³ *Ibid.*, XCI (1934-35), 247 (bibliography of 18 titles).

²³⁴ *Ibid.*, XCV (1938-39), 509 (bibliography of 139 titles).

²³⁵ *Ibid.*, XCIII (1936-37), 829 Manfred Sakel, "Schizophreniebehandlung mittels Insulin-Hypoglykämie sowie hypoglykämischer Schock," *Wien, med. Wochenschr.*, LXXXIV and LXXXV (1934-35)

after the withdrawal of morphine"; but as to schizophrenic patients, "I succeeded at first in pacifying some excited patients; later I went a step further and successfully treated a series of schizophrenic patients at the Vienna University Clinic with very high doses of insulin." Some of the American experiences which grew out of the pioneer work of Dr. Sakel were presented at the Ninety-third Annual Meeting of the American Psychiatric Association, held in 1937, in a "Symposium on Therapy including Hypoglycemia."²²⁶

Somewhat as the treatment of general paralysis with tryparsamide paralleled malaria therapy, chronologically as well as from the standpoint of therapeutic efficacy, so was the treatment of schizophrenia by means of insulin shock paralleled by the use for the same purpose of pentamethylenetetrazol (metrazol) as a convulsive agent; this method was introduced by von Meduna in 1935,²²⁷ and its application in this country was first reported upon in 1937 and 1938.²²⁸ Meduna based the procedure whereby he set up a temporary epileptic state by the use of convulsant drugs upon the not altogether unquestionable assumption of a biologic antagonism between schizophrenia and epilepsy. The question of this antagonism was later investigated by electroencephalography by Jasper, Fitzpatrick, and Solomon, who reported, among other findings, that "a significant number of schizophrenic patients showed electroencephalographic evidence of brain activity similar to that characteristic of the epileptic group."²²⁹

No attempt can be made to cover in any way the literature of shock therapy in schizophrenia (and other mental disorders)—a subject which in the case of convulsive (metrazol) treatment alone had given rise by

²²⁶ *Am J. Psychiatry*, XCIV (1937-38), 89-183.

²²⁷ Ladislaus von Meduna, "Die Konvulsionstherapie der Schizophrenie," *Psych-neurol. Wochenschr.*, XXXVII (1935), 317. "Versuche über die biologische Beeinflussung des Ablaufs der Schizophrenie," *Zeitschr f d ges Neurol u Psychiat*, CLII (1935), 235. "New Methods of Medical Treatment of Schizophrenia," *Arch Neurol and Psychiatry*, XXXV (1936), 361.

²²⁸ Emerick Friedman, "The Irritative Treatment of Schizophrenia: Review of 20 Cases," *Am J Psychiatry*, XCIV (1937-38), 355. H H Goldstein, E F Dombrowski, J V Edlin, A P. Bay, C. L. McCorry, and J Weinberg, "Treatment of Psychoses with Pentamethylenetetrazol," *ibid.*, XCIV (1937-38), 1347; N W. Winkelman, "Metrazol Treatment in Schizophrenia A Study of Thirty-five Cases in Private Practice, Complications and Their Prevention," *ibid.*, XCV (1938-39), 303 (bibliography of 18 titles), Lawrence E Geeslin and Hervey Cleckley, "Anomalies and Dangers in the Metrazol Therapy of Schizophrenia," *ibid.*, XCVI (1939-40), 183 (bibliography of 48 titles).

²²⁹ Herbert H Jasper, Charles P. Fitzpatrick, and Philip Solomon, "Analogies and Opposites in Schizophrenia and Epilepsy Electroencephalographic and Clinical Studies," *ibid.*, XCV (1938-39), 835 (bibliography of 23 titles).

1941 to more than one thousand articles in the world's literature. It will suffice to mention that this literature indicates, for example, that the orthodox insulin shock treatment of Sakel is still the treatment of choice in schizophrenia (its most typical complication, irreversible coma²⁴⁰), while the more drastic convulsive treatment finds its chief sphere of usefulness in the manic-depressive psychoses and in involutional depression²⁴¹ (its chief danger, vertebral fracture²⁴²), since 1941 electroshock has tended to supersede other convulsive techniques.²⁴³ Finally, by 1942 follow-up results in cases treated by means of (insulin) shock were beginning to be published.²⁴⁴

Thus, the subject of therapy bulked larger by far in the American psychiatric literature of the seven-year period since 1937, in particular, than in any previous period of its history. Nor were the several methods of shock treatment, foremost place though they have occupied since the introduction of hypoglycaemic therapy by Sakel, solely responsible for this interest in and emphasis upon treatment, for the latter were manifested in other respects and in other directions as well. To mention certain of these, if only by name:

1. The malaria treatment, and also the tryparsamide treatment, of general paralysis, already sufficiently referred to, dating back in Ameri-

²⁴⁰ Joseph Wortis and Richard H. Lambert, "Irreversible or Hyperglycemic Insulin Coma; Its Cause and Its Response to Blood Transfusion," *ibid*, XCVI (1939-40), 335

²⁴¹ David C. Wilson, "The Results of Shock Therapy in the Treatment of Affective Disorders," *ibid*, XCVI (1939-40), 673.

²⁴² J. V. Edlin and E. S. Klein, "An Improvement in Convulsive Therapy with Metrazol by Premedication with Scopolamine Hydrobromide," *ibid*, XCVII (1940-41), 358 (bibliography of 24 titles); Norman L. Easton and Joseph Sommers, "The Significance of Vertebral Fractures as a Complication of Metrazol Therapy," *ibid*, XCVIII (1941-42), 538

²⁴³ U. Cerletti and L. Bini, "Ueber einige Prinzipien der Anordnung des ersten Elektroschockapparats," *Psychiat-neurol Wochenschr*, XLIII (1941), 211; L. Kalinowsky, N. Bigelow, and P. Brikates, "Electric Shock Therapy in State Hospital Practice," *Psychiat. Q.*, XV (1941), 450. L. H. Smith, J. Hughes, D. W. Hastings, and B. J. Alpers, "Electroshock Treatment in the Psychoses," *Am J Psychiatry*, XCVIII (1941-42), 558. A. Myerson, L. Feldman, and I. Green, "Experience with Electric Shock Therapy in Mental Disease," *New Eng J. Med.*, CCXXIX (1941), 1081; Hans Lowenbach and Edward J. Stainbrook, "Observations on Mental Patients after Electro-Shock," *Am J. Psychiatry*, XCVIII (1941-42), 828.

²⁴⁴ For example. E. D. Bond and T. D. Rivers, "Further Follow-up Results in Insulin-Shock Therapy," *Am J Psychiatry*, XCIX (1942-43), 201; O. J. McKendree, "A Follow-up Study of 87 Cases of Dementia Praecox One to Four Years after Treatment with Insulin Hypoglycaemic Therapy," *Psychiat Q*, XVI (1942), 572, Philip Polatin and Hyman Spotnitz, "Evaluation of the Effects of Intravenous Insulin Technique in the Treatment of Mental Diseases a Follow-up Study of a Group of Patients Treated with Intravenous Injection of Unmodified Insulin and Zinc-Insulin Crystals," *Am J Psychiatry*, XCIX (1942-43), 394.

can psychiatric literature to 1923, and mentioned here only because it was the first example of the latter-day therapy, in the field of the psychoses, under discussion.²⁴⁵

2. With regard to the treatment of manic-depressive psychosis, mention should first be made of Hinsie and Katz's exhaustive review of the "Treatment of Manic-Depressive Psychosis";²⁴⁶ further than this, David C. Wilson's "The Results of Shock Therapy in the Treatment of Affective Disorders,"²⁴⁷ dealing with 37 cases diagnosed as manic-depressive psychosis or involutional melancholia, was one of the relatively few papers concerned with the affective psychoses from the therapeutic standpoint.²⁴⁸

3. Narcosis therapy.²⁴⁹

4. The use of benzedrine sulphate.²⁵⁰

5. Sub-shock therapy, in delirium tremens and in general.²⁵¹

6. Psychoanalysis, which of course much antedates the recent period

²⁴⁵ See. "Psychiatry at the First International Conference on Fever Therapy, Held in New York City, March 29-31, 1937," *Am J Psychiatry*, XCIV (1937-38), 213.

²⁴⁶ *Ibid*, LXXXVIII (1931-32), 131 (bibliography of 24 pages)

²⁴⁷ *Ibid*, XCVI (1939-40), 673.

²⁴⁸ In connection with manic-depressive psychosis, reference should also here be made to the comprehensive survey by McFarland and Goldstein of "The Biochemistry of Manic-Depressive Psychosis a Review" (bibliography of 94 titles), *ibid*, XCVI (1939-40), 21—comparable to their similar surveys of dementia praecox and epilepsy, already referred to (*ibid*, XCV, 509, and XCVI, 771) Mention might also be made of a volume by John T. MacCurdy, entitled *The Psychology of Emotion* (New York, Harcourt, Brace, 1925), since this book is somewhat less a treatment of the psychology of emotion than it is a fully documented clinical discussion of the affective psychoses

²⁴⁹ Harold D. Palmer and Alfred L. Paine, "Prolonged Narcosis as Therapy in the Psychoses," *Am J Psychiatry*, LXXXIX (1932-33), 143 (bibliography of 27 titles); Harold D. Palmer and Francis J. Braceland, "Six Years' Experience with Narcosis Therapy in Psychiatry," *ibid*, XCIV (1937-38), 37 (bibliography of 39 titles), Samuel B. Broder, "Sleep Induced by Sodium Amytal, an Abridged Method for Use in Mental Illness," *ibid*, XCVI (1936-37), 57 (bibliography of 19 titles)

²⁵⁰ A. Myerson, "The Effect of Benzedrine Sulphate on Mood and Fatigue in Normal and Neurotic Persons," *Arch. Neur. and Psychiatry*, XXXVI (1936), 816, Purcell G. Schube, M. C. McManamy, C. E. Trapp, and A. Myerson, "The Effect of Benzedrine Sulphate on Certain Abnormal Mental States," *Am J Psychiatry*, XCIV (1937-38), 27; Eugene Davidoff and Edward C. Reifenshtein, Jr., "The Results of Eighteen Months of Benzedrine Sulphate Therapy in Psychiatry," *ibid*, XCV (1938-39), 945 (bibliography of 41 titles), Wilfred Bloomberg, "Results in the Use of Amphetamine (Benzedrine) Sulphate as an Adjuvant in the Treatment of Chronic Alcoholism," *ibid*, XCVIII (1941-42), 562; Milton Rosenbaum and Louis Lams, "Use of Amphetamine (Benzedrine) Sulphate in the Treatment of Chronic Alcoholism," *ibid*, p. 680

²⁵¹ G. Wilse Robinson, "The Treatment of Delirium Tremens with Insulin in Sub-shock Doses," *ibid*, XCVII (1940-41), 136 (bibliography, chiefly of delirium tremens, of 39 titles), C. R. Bennett and T. K. Miller, "An Observation on the Treatment of Mental Cases with Sub-shock Doses of Insulin," *ibid*, XCVI (1939-40), 961.

above discussed, and of which, equally of course, the field of application is almost exclusively outside of the psychoses. But in its own sphere of applicability psychoanalysis stands alone as a therapeutic technique, and therefore can hardly be omitted from the present discussion of the therapeutic aspects of psychiatry which in other directions have come to occupy the forefront of interest, as we have seen, in more recent years. And while psychoanalysis is no more of American origin than the malaria treatment of general paralysis or the insulin or metrazol shock therapy of dementia praecox, it has become an increasingly integral part of American psychiatry, in the double sense of that receptivity to it first manifested in the invitation to Freud, issued by Drs. G. Stanley Hall and James J. Putnam in 1909, to deliver five lectures on psychoanalysis on the occasion of the twentieth anniversary of the founding of Clark University, and of the fact of its more recent enrichment through the coming to this country of a number of its outstanding exponents from continental Europe.

The American literature of psychoanalysis is divisible, for convenience to its brief discussion here, into articles on the subject contributed to the *American Journal of Psychiatry* and other nonpsychoanalytic periodicals, articles contributed to and forming almost the entire bulk of journals devoted entirely to psychoanalysis, and books on various aspects of psychoanalysis written by American authors. In the first group may be noted the symposium on the relation of psychoanalysis to psychiatry, held at the Ninetieth Annual Meeting of the Association in 1934.²⁶³ In the same group belong such papers as Jamieson and McNiel's "Some Unsuccessful Reactions with Psychoanalytic Therapy,"²⁶³ Abraham Myerson's "The Attitude of Neurologists, Psychiatrists and Psychologists towards Psychoanalysis,"²⁶⁴ Robert P. Knight's "Evaluation of the Results

²⁶³ *Am J Psychiatry*, XCI (1934-35), 1089-1136. Although it is an unwritten law never to mention the name of him who burned down the Temple of Diana at Ephesus in order that his name might descend to posterity, nevertheless one might mention the name of Dr. Frederick Peterson, whose telegram (an integral part of American psychiatric literature, along with rather more intelligent contributions thereto) was read during the discussion of the papers comprising this symposium—a telegram which ran: "It is possible I may be accused of having introduced psychoanalysis into this country If I did, I apologize"

²⁶³ *Ibid.*, XCV (1938-39), 1421.

²⁶⁴ *Ibid.*, XCVI (1939-40), 623 This article presents the results of a poll taken, in which the 307 individuals (including 179 members of the American Psychiatric Association) who replied to the questionnaire classified themselves in one of the following groups. (1) Those individuals who completely accept psychoanalysis; (2) Those who feel very favorably inclined towards it but who do not wholly accept it and are, to a certain extent, skeptical; (3) Those who, in the main, tend to reject its tenets but feel that Freud has contributed

of Psychoanalytic Therapy,"²⁵⁵ and two papers dealing with "that hazy region which is neither psychic nor somatic yet both in one," in the words of Dr. Hutchings: Leon J. Saul's "Hostility in Cases of Essential Hypertension,"²⁵⁶ and Thomas J. French's "Psychogenic Factors in Asthma."²⁵⁷

With regard to the increasingly large literature published in periodicals devoted exclusively to psychoanalysis, reference can here be made only to the periodicals themselves: namely, the pioneer in the field, *The Psychoanalytic Review*, founded in 1913 by Drs. White and Jelliffe (this journal was a pioneer both in the American and the English-language sense, as was the *American Journal of Insanity* in the field of psychiatry); the *Psychoanalytic Quarterly*, founded in 1932 under the editorship of Dr. Dorian Feigenbaum and others; and the *Bulletin* of the Menninger Clinic, founded in 1936.²⁵⁸ Apart from the work of the Chicago Institute for Psychoanalysis, already briefly referred to, nothing can here be said of the content of these journals, with the single further exception of a mention of the recent work of Dr. Dexter M. Bullard and his associates in the psychoanalytic treatment of psychotic patients.²⁵⁹

indirectly to the human understanding; (4) Those who feel that his work has, on the whole, hindered the progress of the understanding of the mental diseases and the neuroses and reject him entirely. Several of those who replied found these categories, as here formulated, a rather too Procrustean bed, but at all events, of the 179 members of the American Psychiatric Association who replied, 25 classed themselves in the first group, 15 between the first and second, 54 in the second group, 32 between the second and third, 39 in the third group, and 8 between the third and fourth, with none in the fourth group. It is of interest to compare with this the Presidential Address delivered in the same year (1939) by Dr. Richard H. Hutchings (*ibid.*, XCVI, 1939-40, 1), whose remarks on the place and value of psychoanalysis have a considerable pertinence to Myerson's article

²⁵⁵ *Ibid.*, XCVIII (1941-42), 434 (bibliography of 9 titles)

²⁵⁶ *Ibid.*, XCV (1938-39), 1449 (bibliography of 6 titles).

²⁵⁷ *Ibid.*, XCVI (1939-40), 87. These two papers are among the later products of the Chicago Institute for Psychoanalysis, whose work in the psychosomatic field goes back to the publication in 1934 of "The Influence of Psychologic Factors upon Gastro-intestinal Disturbances a Symposium," by Franz Alexander and others (*Psychoanalytic Quarterly*, III, 1934, 501). Mention should here be made, also, of the founding in January, 1939, under the editorship of Dr. Flanders Dunbar (whose encyclopedic survey of the psychosomatic field, *Emotions and Bodily Changes*, was published in 1935), of the quarterly periodical *Psychosomatic Medicine*, published with the sponsorship of the Committee on problems of neurotic behavior, Division of anthropology and psychology, National Research Council

²⁵⁸ Not a psychoanalytic journal, but belonging here chronologically, is the quarterly periodical, *Psychiatry*, founded in 1938, and published by the William Alanson White Psychiatric Foundation.

²⁵⁹ See for example Frieda Fromm-Reichmann, "Transference Problems in Schizophrenics," *Psychoanalytic Q.* VIII (1939), 412; Dexter M. Bullard, "Experiences in the Psychoanalytic Treatment of Psychotics," *ibid.*, IX (1940), 493, "The Organization of Psychoanalytic Procedure in the Hospital," *J. Nerv. and Mental Dis.*, XCI (1940), 697, Frieda Fromm-Reichmann, "Psychoanalytic Psychotherapy with Psychotics," *Psychiatry*, VI (1943), 277

The list of books on psychoanalytic subjects by American authors is a brief one, certainly by comparison with the number emanating from England. Among these few may be mentioned in particular Franz Alexander's *The Medical Value of Psychoanalysis* (second edition, New York, 1936),²⁰⁰ Franz Alexander and William Healy's *Roots of Crime: Psychoanalytic Studies* (New York, 1935); Lawrence S. Kubie's *Practical Aspects of Psychoanalysis* (New York, 1936); Ives Hendrick's *Facts and Theories of Psychoanalysis* (second edition, New York, 1939), without much question the best general account of psychoanalysis in English; and four volumes addressed in part or wholly to the layman—Karl Menninger's *The Human Mind* (second edition, New York, 1937), *Man Against Himself* (New York, 1938), and *Love Against Hate* (New York, 1942), and Gregory Zilboorg's *Mind, Medicine and Mankind* (New York, 1943). Perhaps there should be added to these examples, since they are not translations, two books by Géza Róheim on the application of psychoanalytic principles to anthropology: *Social Anthropology* (New York, 1926), and *Animism, Magic and the Divine King* (New York, 1930).

A recent development in American psychiatry, one in the field not of therapy but of diagnosis, remains to be mentioned: electroencephalography, the recording of the electrical activity of the cortex—a subject which made its first clinical appearance in American psychiatric literature in 1935,²⁰¹ two years after the series of articles by Hans Berger in the *Archiv für Psychiatrie und Nervenkrankheiten* (1929–1933). Clinical applications of electroencephalography during the period since elapsed have included epilepsy,²⁰² behavior disorders in children,²⁰³ schizophrenia,²⁰⁴ ma-

²⁰⁰ The first edition of this work (1932) was the occasion of a slightly acrimonious discussion in the pages of the *Journal*, when Bernard Sachs reviewed it under the title, "The False Claims of the Psychoanalyst: a Review and a Protest" (*Am. J. Psychiatry*, LXXXIX, 1932–33, 725); Alexander replied with "A Voice from the Past: Some Remarks on Dr. Bernard Sachs' Protest against Psychoanalysis" (*ibid.*, XC, 1933–34, 193), the utter perfection of this title may commend the article to the reader.

²⁰¹ F. A. Gibbs, E. L. Gibbs, and W. G. Lennox, "The Electroencephalogram in Epilepsy and in Conditions of Impaired Consciousness," *Arch. Neurol. and Psychiatry*, XXXIV (1935), 1153.

²⁰² Herbert H. Jasper and Ira C. Nichols, "Electrical Signs of Cortical Function in Epilepsy and Allied Disorders," *Am. J. Psychiatry*, XCIV (1937–38), 835 (bibliography of 22 titles); F. A. Gibbs, E. L. Gibbs, and W. G. Lennox, "The Likeness of the Cortical Dysrhythmias of Schizophrenia and Psychomotor Epilepsy," *ibid.*, XCV (1938–39), 255; Joseph W. Owen and Louis Berlinrood, "Clinical and Electroencephalographic Studies in Pyknolepsy," *ibid.*, XCVIII (1941–42), 757 (bibliography of 23 titles).

²⁰³ Herbert H. Jasper, Philip Solomon, and Charles Bradley, "Electroencephalographic Analysis of Behavior Problem Children," *Am. J. Psychiatry*, XCV (1938–39), 641 (bibliography of 18 titles); Norman Q. Brill, Herta Seidemann, Helen Montague, and Ben H. Balser, "Electroencephalographic Studies in Delinquent Behavior Problem Children," *ibid.*, XCVIII

nic-depressive psychosis,²⁹⁵ and organic psychoses.²⁹⁶ As to the entire subject of electroencephalography, reference must be made in particular to F. A. and E. L. Gibb's comprehensive *Atlas of Electroencephalography* (Cambridge, Mass., 1941).

This chapter—which has with inevitable and only too numerous lacunae attempted to survey one hundred years of American psychiatric literature—began with an allusion to the world situation which prevailed at the time of its writing, a situation unprecedented and unparalleled, in respects which need no mention, in the history of mankind, until it must seem to the psychiatrist no less than to the poet that the troubles of our proud and angry dust are from eternity, and shall not fail. Perhaps, therefore, the chapter might well close on a similar note. If so, we could not do better than turn to the Presidential Address on "Perspectives in Psychiatry," delivered at the Ninety-third Annual Meeting of the American Psychiatric Association in 1937 by the late Dr. C. Macfie Campbell, philosopher among American psychiatrists.²⁹⁷ In this address, one of the most able delivered before the Association, Dr. Campbell referred to the fact that

In the complicated field of human relations there is no single feature so startling as the mass destruction of one's fellow creatures because of conflicts as to beliefs or material possessions. Yet war is a commonplace, it is accepted by some as if it were an inevitable condition of human existence on this planet,

(1941-42), 494, Warren T. Brown and Charles I. Solomon, "Delinquency and the Electroencephalograph," *ibid.*, 499

²⁹⁴ Hudson Hoagland, Morton A. Rubin, and D. Ewen Cameron, "The Electroencephalogram of Schizophrenics during Insulin Hypoglycemia and Recovery," *Am. J. Physiol.*, CXX (1937), 599, Hoagland, Cameron, and Rubin, "The Electroencephalogram of Schizophrenics during Insulin Treatments: the Delta Index as a Clinical Measure," *Am. J. Psychiatry*, XCIV (1937-38), 183, Pauline A. Davis and Hallowell Davis, "The Electroencephalograms of Psychotic Patients," *ibid.*, XCV (1938-39), 1007 (bibliography of 16 titles), P. A. Davis, "Evaluation of the Electroencephalograms of Schizophrenic Patients," *ibid.*, XCVI (1939-40), 851 (bibliography of 14 titles), Morton A. Rubin, "Electroencephalography in the Psychoses," *ibid.*, 861, Knox H. Finley and Joseph M. Lesko, "EEG Studies of Nine Cases with Major Psychoses Receiving Metrazol," *ibid.*, XCVIII (1941-42), 185, Knox H. Finley and C. Macfie Campbell, "Electroencephalography in Schizophrenia," *ibid.*, 374; Roy R. Grinker and Herman M. Seidota, "Electroencephalographic Studies of Corticohypothalamic Relations in Schizophrenia," *ibid.*, 385.

²⁹⁵ Pauline A. Davis, "Electroencephalograms of Manic-Depressive Patients," *Am. J. Psychiatry*, XCVIII (1941-42), 430, Pauline A. Davis, "Comparative Study of the EEGs of Schizophrenic and Manic-Depressive Patients," *ibid.*, XCIX (1942-43), 210 (bibliography of 19 titles)

²⁹⁶ Paul Hoch and Joseph Kubis, "Electroencephalographic Studies in Organic Psychoses," *ibid.*, XCVIII (1941-42), 404 (bibliography of 11 titles)

²⁹⁷ *Am. J. Psychiatry*, XCIV (1937-38), 1.

as if human nature had some ineradicable tendency bound to express itself in recurrent outbursts of mutual destruction. With this fatalistic attitude all the skill and all the intellectual processes of man may be made subservient to the accomplishment of this destructive task.

It was therefore refreshing to hear a different note sounded by a group of men whose life task was to study the underlying urges of human nature, the results of their frustrations, the lines along which one might strive to reach a wholesome solution for the problems of the individual and the social group. This group of men started from no dogma, could not be accused of unfamiliarity with scientific method, their life had accustomed them to the exercise of critical judgment. They were familiar with the principles of the physical and the biological sciences, they were no group of visionaries. I refer to the appeal sent out in 1935 to all the statesmen of the world by a group of 340 psychiatrists and psychologists from 27 countries. This appeal was formulated by the Committee for War Prophylaxis of the Netherlands Medical Association.²⁶⁸ . . . The challenge issued by the Netherlands physicians may cause searching of heart, and lead to clarification of our psychiatric thought in relation not only to the issue raised by the appeal, but to other social issues. . . . War is a big topic, international relations are complicated, humanity is a large concept. It may be wise at the beginning to realize that the scope of our minds is limited, that few can think in international terms; we use big words and feel that we are grasping large areas of space and a wide expanse of time, but these words in actuality have a marked personal and regional quality. We fail to realize the parochial limitations of our mind but talk glibly of universal peace. In view of these limitations, with peace as with charity it may be well to begin at home. Success in dealing with the more immediate problems may fit the individual and the community to deal more adequately with the wider problems; it may even enable the statesmen to deal in a more rational and objective way with problems which involve the peace of the nations. . . .

Although one may have no illusion as to the immediate effect of knowledge and reason on the conduct of human affairs, one may still have faith in their irresistible if slow penetration. The physical world once seemed rather a muddle, full of unexplained and unpredictable events; man has elicited many of its secrets, and the control of the forces of nature thus gained has made man's life less "solitary, poor, nasty, brutish and short." . . . In the muddled state of human affairs blind instinctive and unconscious forces will continue to be operative, but it is our task to see that rational considerations play an increasingly important role. Foremost among these considerations is sound knowledge of the component forces of human nature, and of the forces at play in group life. . . .

It is the function of the American Psychiatric Association . . . to make the connection between the work of the individual psychiatrist and the progress of human culture, suggested in this paper, so clear that he who runs may read.

²⁶⁸ Its text is reproduced in the *Journal*, XCII (1935-36), 739-741.

SOME IMPORTANT BOOKS IN AMERICAN PSYCHIATRY

PUBLISHED DURING THE LAST TWENTY-FIVE YEARS

American translations have not been included in this check-list since they are not of American origin, although through translation they have been made a part of American psychiatric literature. Thus, such notable works are omitted as, for example, Bleuler's *Textbook of Psychiatry* (1924), Paul Schilder's *Introduction to Psychoanalytic Psychiatry* (1928), Alexander and Staub's *The Criminal, the Judge and the Public* (1931), and the American translations of a number of Freud's works.

- 1916. Henry M. Hurd, ed. *History of the Institutional Care of the Insane in the United States and Canada*. 4 vols. Baltimore, Johns Hopkins Press
- 1920. E. J. Kempf. *Psychopathology*. St. Louis, Mo., Mosby.
- 1921. August Hoch. *Benign Stupors*. New York, Macmillan
- 1921. William A. White. *Foundations of Psychiatry*. New York, Nervous and Mental Disease Publishing Co.
- 1923. William A. White. *Insanity and the Criminal Law*. New York, Macmillan.
- 1925. John T. MacCurdy. *The Psychology of Emotion*. New York, Harcourt.
- 1925. Sheldon Glueck. *Mental Disorder and the Criminal Law*. Boston, Little, Brown.
- 1926. William Healy and Augusta F. Bronner. *Delinquents and Criminals; Their Making and Unmaking*. New York, Macmillan.
- 1928. William G. Lennox and Stanley Cobb. *Epilepsy*. Baltimore, Williams and Wilkins
- 1930. Sheldon Glueck and Eleanor T. Glueck. *Five Hundred Criminal Careers*. New York, Knopf.
- 1930. Harold D. Lasswell. *Psychopathology and Politics*. Chicago, Univ. of Chicago Press.
- 1933. C. Macfie Campbell. *Towards Mental Health: the Schizophrenic Problem*. Cambridge, Mass., Harvard Univ. Press.
- 1933. William A. White. *Forty Years of Psychiatry*. New York, Nervous and Mental Disease Publishing Co.
- 1934. Bentley and Cowdry, eds. *The Problem of Mental Disorder*. New York and London, McGraw Hill.
- 1934. C. Macfie Campbell. *Human Personality and the Environment*. New York, Macmillan.
- 1934. Sheldon Glueck and Eleanor T. Glueck. *One Thousand Juvenile Delinquents: Their Treatment by Court and Clinic*. Cambridge, Harvard Univ. Press.
- 1934. George S. Stevenson and Geddes Smith. *Child Guidance Clinics, a Quarter Century of Development*. New York, Commonwealth Fund.

- 1935 Franz Alexander and William Healy. *Roots of Crime: Psychoanalytic Studies*. New York, Knopf.
1935. C. Macfie Campbell. *Destiny and Disease in Mental Disorders*. New York, Norton
1935. George W. Henry *Essentials of Psychopathology*. Baltimore, Wood.
1935. William Malamud *Outlines of General Psychopathology*. New York, Norton.
- 1935 Smith Ely Jelliffe and William A. White *Diseases of the Nervous System*. 6th ed. Philadelphia, Lea and Fibiger.
1935. Leo M Kanner. *Child Psychiatry*. Springfield, Charles C Thomas.
1936. Franz Alexander. *The Medical Value of Psychoanalysis*. 2d ed. New York, Norton
1936. William A Bryan. *Administrative Psychiatry*. New York, Norton.
- 1936 Oskar Diethelm. *Treatment in Psychiatry* New York, Macmillan.
1936. Lawrence S. Kubie. *Practical Aspects of Psychoanalysis*. New York, Norton.
- 1936 Nolan D. C Lewis. *Research in Dementia Praecox (Past Attainments, Present Trends and Future Possibilities)*. New York, National Committee for Mental Hygiene.
- 1936 Abraham Myerson, James B. Ayer, Tracy J. Putnam, Clyde E. Keeler, and Leo Alexander. *Eugenical Sterilization: a Reorientation of the Problem*. New York, Macmillan.
1936. William A White. *Twentieth Century Psychiatry (Its Contribution to Man's Knowledge of Himself)*. New York, Norton.
1937. Albert Deutsch. *The Mentally Ill in America: a History of Their Care and Treatment from Colonial Times*. New York, Doubleday.
1937. Sheldon Glueck and Eleanor T Glueck. *Later Criminal Careers*. New York, Commonwealth Fund.
1937. James S. Plant. *Personality and the Cultural Pattern*. New York, Commonwealth Fund.
1937. A. F. Tredgold. *A Text-Book of Mental Deficiency*. 6th ed. Baltimore, Wood.
1938. Flanders Dunbar. *Emotions and Bodily Changes: a Survey of Literature on Psychosomatic Interrelationships*. 2d ed. New York, Columbia Univ. Press.
1938. Karl A. Menninger. *Man Against Himself*. New York, Harcourt, Brace.
1938. Henry A Murray. *Explorations in Personality*. New York, London, Toronto, Oxford Univ. Press.
1938. Aaron J. Rosanoff. *Manual of Psychiatry*. 7th ed. New York, Wiley.
1938. William A White. *William Alanson White: the Autobiography of a Purpose*. New York, Doubleday.
1939. Ives Hendrick. *Facts and Theories of Psychoanalysis*. 2d ed. New York, Knopf.
1939. Abram Kardiner. *The Individual and His Society*. New York, Columbia Univ. Press.

1939. Wendell Muncie. *Psychobiology and Psychiatry*. St. Louis, Mo , Mosby
- 1939 Horatio M. Pollock, Benjamin Malzberg, and Raymond G Fullen
Heredity and Environmental Factors in the Causation of Manic-Depressive Psychoses and Dementia Praecox. Utica, N. Y., State Hospitals Press.
1940. J. F. Brown *The Psychodynamics of Abnormal Behavior*. New York, McGraw
1940. Neil A. Dayton. *New Facts on Mental Disorders*. Springfield, Ill , C C Thomas
1940. Lois Meredith French *Psychiatric Social Work* New York, Commonwealth Fund.
1940. Leland E. Hinsie and Jacob Shatzky *Psychiatric Dictionary*. New York, Oxford Univ. Press.
1940. Edward A Strecker and Franklin G. Ebaugh *Practical Clinical Psychiatry*. 5th ed Philadelphia, Blakiston
1940. Helen Leland Witmer *Psychiatric Clinics for Children* New York, Commonwealth Fund.
1941. András Angyal *Foundations for a Science of Personality* New York, Commonwealth Fund *
1941. D. Ewen Cameron. *Objective and Experimental Psychiatry* 3d ed New York, Macmillan.
1941. Stanley Cobb *Foundations of Neuropsychiatry*. 2nd ed Baltimore, Williams and Wilkins.
1941. F. A. Gibbs and E L. Gibbs. *An Atlas of Electroencephalography*. Cambridge, Mass , Lew A Cummings Co.
1941. George W Henry *Sex Variants a Study of Homosexual Patterns* 2 vols. New York, Harper.
- 1941 Lucie Jessner and V Gerard Ryan *Shock Treatment in Psychiatry a Manual* New York, Grune & Stratton.
1941. William G Lennox *Science and Seizures. New Light on Epilepsy and Migraine*. New York, Harper.
1941. A. H. Maslow and Béla Mittelmann. *Principles of Abnormal Psychology: the Dynamics of Psychic Illness* New York, Harper.
1941. Horatio M Pollock *Mental Disease and Social Welfare* Utica, State Hospitals Press.
1941. Robert Waelder. *The Living Thoughts of Freud*. New York, Longmans.
1941. Anna M Wolf. *The Parents' Manual* New York, Simon and Schuster.
1941. Gregory Zilboorg. *A History of Medical Psychology* New York, Norton.
1942. Frederick H. Allen. *Psychotherapy with Children*. New York, Norton.
- 1942 Franklin G Ebaugh and Charles A Rymer *Psychiatry in Medical Education* New York, Commonwealth Fund.
- 1942 E M. Jellinek, ed *Alcohol Addiction and Chronic Alcoholism*. Vol. I. New Haven, Yale Univ. Press.

1942. Edward A. Strecker. *Fundamentals of Psychiatry*. Philadelphia, Lippincott.*
1943. Stanley Cobb. *Borderlands of Psychiatry*. Cambridge, Mass., Harvard Univ. Press.
1943. Flanders Dunbar. *Psychosomatic Diagnosis*. New York, Paul Hoeber.
1943. Arnold Gesell and Frances L. Ilg. *Infant and Child in the Culture of Today*. New York, Harper.
1943. David M. Levy. *Maternal Overprotection*. New York, Columbia Univ. Press.
1943. Jules Masserman. *Behavior and Neurosis*. Chicago, Univ. of Chicago Press.
1943. Robert R. Sears. *Survey of Objective Studies of Psychoanalytic Concepts*. New York, Social Science Research Council.
1943. Edward Weiss and O. Spurgeon English. *Psychosomatic Medicine; the Clinical Application of Psychopathology to General Medical Problems*. Philadelphia and London, Saunders.
1943. Gregory Zilboorg. *Mind, Medicine and Man*. New York, Harcourt, Brace.
1944. Henry B. Richardson. *Patients Have Families*. New York, Commonwealth Fund.

AMERICAN PSYCHIATRIC PERIODICALS

The American Journal of Insanity. Ed. Amariah Brigham *et al.* Vol. I, No. 1, July, 1844—Vol. LXXVII, No. 4, April, 1921.

Superseded by.

The American Journal of Psychiatry. Vol. LXXVIII, No. 1, July, 1921—(Vols. LXXVIII—XC also numbered, New Series, Vols. I—XIII)

The American Psychological Journal. Ed. Edward Mead. Vol. I, Nos. 1–6, 1853.

The Quarterly Journal of Psychological Medicine and Medical Jurisprudence.

Ed. William A. Hammond. Vol. I, No. 1, July, 1867—Vol. III, No. 2, October, 1869.

Superseded by.

The Journal of Psychological Medicine. A quarterly review of diseases of the nervous system, medical jurisprudence and anthropology. Ed. William A. Hammond, Vol. IV, No. 1, January, 1870—Vol. VI, No. 4, October, 1872.

The Psychological and Medico-legal Journal. A monthly review of diseases of the mind and nervous system and of medical jurisprudence. Vols. I—III, July, 1874—May, 1876.

The Chicago Journal of Nervous and Mental Disease. Ed. J. S. Jewell. Vols. I—II, 1874–1875.

Superseded by:

The Journal of Nervous and Mental Disease. Ed. J. S. Jewell and H. M. Bannister. Vol. III, No. 1, January, 1876—

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THE HISTORY OF PSYCHIATRIC
THERAPIES

PSYCHIATRY occupies a unique position in relation to the biological, psychological, and social sciences, and the developments in these fields have had a direct influence on psychiatric treatment. In no branch of medicine does the success of treatment depend so much upon the general environment of the patient as it does in psychiatry. The architectural characteristics of the hospital, its size or location, the availability of proper occupation for the patients, all play an important part in the planning of a therapeutic program. A comprehensive history of psychiatric treatment, therefore, would have to take into consideration the development of all of these factors and their influence upon the treatment of mental patients at any given period. It would have to tell the story of the development, for instance, of a hospital dining room, side by side with that of changes in the attitudes of judges and legislatures. It would have to trace the history of antiluetic therapy or brain surgery as well as the developments of religious sects or popular prejudices. Such a comprehensive survey is not the goal of this chapter, for it is limited to the period of the century of our Association's existence. However, this temporal limitation does not materially restrict its general scope; psychiatric treatment as we know it today was practically nonexistent before the closing years of the eighteenth century, and many of the methods of treatment utilized in the days before Rush, Pinel, and Tuke had to be thoroughly abandoned before rational scientific and humanitarian methods could be developed.

At most of the annual meetings of the Association the subject of treatment has been dealt with to a greater or less extent. In following the proceedings of these meetings we find a waxing and waning of interest in one form of treatment or another, depending upon needs as they arose, discoveries as they were introduced, fads as they came and went, leaders as their influence upon the group rose or fell.

At first glance the introduction of new points of view or methods of practical procedure seems to follow fairly closely upon the heels of important discoveries or contributions. Thus it can be seen that interest in and contributions to the treatment of general paresis followed almost immediately upon the introduction of the Wassermann test and Noguchi and

Moore's discovery. Similarly, progress in psychotherapy and mental hygiene followed closely upon the contributions of Freud and Meyer. At the same time, however, it is also true that frequently there was a lag between the appearance of certain new contributions and the manifestation of their effects. This is especially true in regard to the developments preceding the foundation of the Association and their influence not only upon the status of treatment in 1844 but upon subsequent developments for a good many years.

The fact that the medical superintendents of thirteen of the then existing hospitals for mental diseases came together to organize "The Association of Medical Superintendents of American Institutions for the Insane"¹ cannot be regarded as an isolated incident. Like any other social event, it must be regarded as the observable manifestation of processes that had been in development for years before and which culminated in the need for such an association at that time. In order to understand this need and the subsequent developments in the life of the Association, we must know, in a general way, the nature of these processes and their effects upon the progress of therapy. Those interested especially in historical matters, and who may wish to study the developments through the ages, will find useful information in such contributions as Friedreich,² Kirchhoff³ and Hurd⁴ on psychiatry in general; Deutsch⁵ on American psychiatric history; Zilboorg⁶ on the history of medical psychology, as well as general texts on the history of medicine.

In dealing with the material of this chapter, we might well start with an event that definitely marks a turning point in the treatment of the insane in this country—that is, the founding of the Pennsylvania Hospital in 1752⁷ and the inclusion in it of a special section for the insane. The darkest period of the history in this field, culminating in the execution of obviously insane persons as witches, had ended—except for sporadic instances—more than half a century before this date. As far as the institution of medical treatment or a generally improved humane interest in

¹ "Report of the First Meeting of the Medical Superintendents," *Am J Insanity*, I (1845), 253

² I. B. Friedreich, *Versuch einer Literaturgeschichte der Pathologie und Therapie der psychischen Krankheiten* (Wurzburg, 1830)

³ Kirchhoff, *Geschichte der Psychiatrie (Handbook of Psychiatry)* ed Aschaffenburg (Leipzig, 1912)

⁴ Hurd, ed., *The Institutional Care of the Insane in the United States and Canada* (Baltimore, Johns Hopkins Press, 1916-17)

⁵ Albert Deutsch, *The Mentally Ill in America* (New York, Doubleday, Doran, 1937)

⁶ Gregory Zilboorg, *A History of Medical Psychology* (New York, W W Norton, 1941)

⁷ Deutsch, *op cit.*, p 60.

these unfortunates was concerned, however, matters did not materially improve during the early part of the eighteenth century.⁸ No attempt at hospitalization was made in the United States until the founding of the Pennsylvania Hospital. It is true that as far as medical treatment is concerned the patients here did not fare much better than before. They were relegated to the basement of the hospital, and their treatment was not far in advance of the practices of the day. Chains were still used liberally, punishment was considered a necessity, and medication consisted mainly of venesection, blistering, and purging. Nevertheless, it represents the first instance of an attempt at medical treatment of such cases as legitimate patients of a general hospital.

Progressive ideas take root slowly and their effect upon the community at large lags behind their original inception. But it was only some twenty years after the founding of the Pennsylvania Hospital that the next step in this direction was taken and the first American asylum for the mentally sick was opened in Williamsburg, Virginia, in 1773.⁹ Meanwhile, the revolution in this country and the revolution in France, resulting in far-reaching social and political changes, and the Industrial Revolution with its effect upon economic and social life had deeply influenced the whole system of interpersonal relations. The spirit of humanitarian treatment of individuals and the growing consideration of their rights as human beings very soon showed their effects in various countries, and reforms in the care and treatment of the mentally sick followed almost immediately. Of the men who served as the guiding spirits in such reforms, particularly in regard to their influence on this country, three stand out as the most important: Rush, Pinel, and Tuke.

Rush, who is deservedly known as the father of American psychiatry, joined the staff of the Pennsylvania Hospital in 1783,¹⁰ and from the beginning of his work there he showed his great interest in and made many contributions to the study and treatment of the insane. Obviously he had little to work with. Not much scientifically valid knowledge about the nature of mental diseases was available and, in keeping with that fact, the attempts at treatment were either purely empirical or based upon untested theories of the causes of these diseases. Rush was an adherent of that school which claimed that insanity was largely due to diseases of the

⁸ For a discussion of this early period, see Professor Shryock's and Dr. Hamilton's chapters in this volume.

⁹ Deutsch, *op. cit.*, p. 66

¹⁰ *Ibid.*, p. 73

blood vessels of the brain, a reduction of the congestion of these blood vessels was therefore indicated.¹¹ Rush advocated liberal venesection and general depletion, consisting of low diet, drastic purges, emetics, and other methods whereby it was felt that the condition of the blood vessels would be reduced to as low an ebb as that of the nervous system, following which the building up of both could be attempted. At the same time, however, Rush advocated moral treatment, some elements of which were definitely beneficial and far in advance of his time. He was a great believer in work as a means of interesting the patients in their environment, and felt that if their minds were kept busy they could be distracted from their abnormal fantasies. Rush urged kindness and humane interest in patients, and proper supervision of their attendants. Even in this respect, however, some of his methods were distinctly survivals of older traditions, chief among which were the devices that he constructed for the purpose of mechanical restraint. The so-called "tranquilizer" and "gyrator," although not quite so crude and painful as some that were used both before and for a long time after him, were still fairly primitive instruments.

In evaluating the contributions of Rush to the treatment of mental diseases, we must take into account the times in which he lived and the theories which had become firmly entrenched in the minds of the medical profession at the time. The combination of logical reasoning based upon keen observation with an adherence to established customs can be followed in all the other therapeutic methods advocated by Rush. Thus, while he recognized the value and importance of hydrotherapy, he still advocated the heroic methods of the time: cold shower baths of from ten to fifteen minutes, the pouring of cold water under the sleeves so that it might descend into the armpits and down the trunk. Whatever we may think now of the validity of such methods, we must appreciate that the influence of Benjamin Rush upon American psychiatry was deep and lasting.¹²

At the same time the influences of European reforms in the field of the mentally sick began to be felt in this country. Chief among these were the teachings of Pinel and his pupil Esquirol in France, and those of Tuke and Conolly in England. Whereas Rush still stressed the use of surgery and drugs as the nucleus of his approach, with moral treatment as a kind

¹¹ E. Cowles, "Progress in the Care and Treatment of the Insane," *Am. J. Insanity*, LI (1894), 10.

¹² See Benjamin Rush, *Medical Inquiries and Observations upon the Diseases of the Mind* (Philadelphia, Grigg, 1812)

of superstructure, the Europeans, and particularly Tuke and Conolly, placed their main emphasis on humanitarian principles and the so-called moral treatment. Pinel was the first man to remove the chains from the mentally ill, as he was the first in France to introduce a humane attitude into this field. He was skeptical of the value of venesection and drugs and emphasized moral therapy, an attitude expressed in the very title of his book, *Traité Médico-philosophique sur l'Aliénation Mentale*. Pinel stressed the need for treating the mentally ill as human beings who are sick rather than as animals or criminals. He advocated nonrestraint, kindness, and good hygienic conditions in the hospitals where these patients were placed.

Still further progress in this direction was introduced by William Tuke in the Retreat which he founded in York, England, in 1792. Tuke was not a physician but a prominent member of the Society of Friends, who were responsible for the building and upkeep of the hospital. The fundamental policy introduced by Tuke was the use of moral treatment, as contrasted with restraint and punishment on the one hand and the all too liberal use of surgery and drugs on the other. These reforms gradually developed the following main trends: 1) Hospitalization of the mentally sick as contrasted with private care and treatment; 2) the development of specifically mental hospitals, with personnel specially trained for this type of work; 3) moral and humanitarian treatment as contrasted with the then current physical or legalistic approaches.

It is obvious that of the two opposing trends, the one followed by William Tuke came nearer to dealing with the actual causes of mental diseases than the purely fantastic and scientifically invalid attempts at organic treatment of the time. The method used by Tuke bears a closer relation to our present-day psychotherapeutic methods than the theory of arterial pathology bears to our contemporary theories of organic pathology in the mental diseases. No wonder, therefore, that in the early days of the nineteenth century, the practical-minded American psychiatrists began to turn away from venesection and to adopt the methods of Pinel and Tuke. The hospitals which were being established in this country at that time—Frankford, McLean, Bloomingdale, and the Hartford Retreat—were all patterned along the lines of the Retreat at York; the chief methods of treatment were those advocated by Pinel and particularly by Tuke. This was the trend that was emerging shortly before the foundation of the Association, but in the development of psychiatry

then and for some time after 1844 three other important influences left their imprint upon psychiatric treatment. the "cult of curability" started around 1820; the crusade against restraint started by Conolly, and the work of Dorothea Lynde Dix in the development of hospitals for the care and treatment of the insane here and abroad.

However, the practical results, in so far as the treatment of the majority of mentally sick persons was concerned, were actually quite small. These four hospitals were small and admitted only private patients; the status of indigent patients remained the same. Almshouses for the quiet and innocuous, imprisonment and chains for the violent, were still in common practice. Restraint, punishment, absence of any kind of general hygiene were the rule, while medical treatment for those outside of hospitals was nonexistent. It is obvious that under such conditions few patients could recover. It is equally obvious that patients in such hospitals as the York Retreat or hospitals like it in this country were much more prone to show improvement than those who were not treated at all. Thus the introduction of the new type of treatment of the mentally sick actually did result in dispelling the belief that all mental diseases were incurable. Unfortunately, however, the proponents of the new methods in their confidence and enthusiasm overshot the mark, claiming more numerous cures and better prognoses than the facts justified. Briefly stated, this "cult of curability" claimed that mental diseases, when properly treated in special hospitals using modern therapies and equipped with proper personnel, were by far the most curable of all diseases. Even the most conservative psychiatrists of the day, realizing the value of such claims in influencing public opinion and legislatures for the purpose of building more hospitals, followed the majority and contrived means for fitting such statements into the limits of their consciences.

Several results of this movement must be taken into consideration in our evaluation of the status of psychiatric treatment in 1844. One was the trend toward building not only more hospitals but hospitals that were specifically adapted to psychiatric treatment. It meant hospitalization versus private treatment on the outside; separate asylums rather than wards in connection with general hospitals, location of these asylums in places where work on farms, in industrial shops, and so forth was possible. More important, it led to the specialization of physicians in the particular field of psychiatry. Finally it meant segregation or "classification," which implied the separation of acute cases from the chronic deteriorated ones—

ostensibly because in this way the deleterious effect of the chronically ill upon the new cases could be avoided, actually because it was noticed quite early that the acute cases were more likely to recover.

A second important influence on psychiatry was the English crusade against mechanical restraint. There is no question that even after the teachings of Pinel, Tuke, and Rush had begun to take a strong hold on the profession, restraint—though not quite so crude as that practiced before—was still prevalent. It is true that the tranquilizer and gyrator did not carry the implications of chains and the whip, but they certainly did not indicate a complete abolition of mechanical restraint. In fact, even long after 1844 numerous instances of restraint of the crudest type could be found—White for instance tells of finding the “saddle” still in use at St. Elizabeths in 1903,¹³ and in some isolated instances certain types of restraint reminiscent of the old days could be seen even in recent years. It is understandable, then, that at about the time that the propaganda for moral treatment was at its peak some of its most enthusiastic proponents took the stand that mechanical restraint must be abolished entirely if moral treatment was to be followed to its logical conclusion. And there began the crusade for complete nonrestraint.

The most ardent exponent of this system was Conolly, who proceeded to put such a system into effect when he was appointed superintendent at the Middlesex Asylum in England in 1839.¹⁴ A violent controversy ensued, in this country it was particularly bitter and it continued to come up in discussions at the meetings of the Association for many years.¹⁵ There was a certain basic validity in the arguments that the abolition of mechanical restraint would bring in some form of physical restraint by attendants who, in their ignorance, would use intimidation and force which would often result in bodily injury; it is true also that the use of chemical agents to keep the patients in a state of semi-stupor most of the time was hardly less injurious than mechanical restraint. However, non-restraint eventually won out, in line with progressive developments in the understanding of the problems of the mentally sick, and thus justified its proponents.

The vigorous battle to abolish restraint had two important effects. It was a powerful argument in convincing the lay public of the desirability

¹³ Wm A White, *Forty Years of Psychiatry* (New York and Washington, Nervous and Mental Disease Monog., 1933).

¹⁴ Deutsch, *op cit*, p 214

¹⁵ O Everts, “Treatment of the Insane,” *Am. J. Insanity*, XLI (1884), 158.

of and necessity for building new hospitals which stood for humane and intelligent care for the insane. Further, when a definite stand on this argument had been taken it became incumbent upon the hospitals not to permit the practice of the cruelties they had so vigorously condemned.

New methods of treatment of the mentally ill become effective only on the basis of forceful presentation of the facts to those who are in a position to pass legislation making them possible. Outstanding in bringing these issues before the public was a small group of enlightened, nonpsychiatric crusaders of whom the most important was Dorothea Lynde Dix.³⁶ Her keen and realistic appreciation of the unjust and inhuman treatment of the insane, her firm belief that hospitalization and treatment under proper conditions would result in helping most of them—a belief stimulated by the cult of curability—and her forceful personality and resourceful mind did more for the development of modern psychiatric hospitals and proper management and care of patients than has been achieved by any other lay person. Here again, then, a trend developed which in conjunction with the cult of curability and the nonrestraint movement tended toward the results mentioned above—the segregation of patients into specially constructed hospitals, primarily for the purpose of applying moral treatment. There is no question but that under the then existing conditions this was the best practical measure. Nevertheless, it had its disadvantages which only comparatively recently have begun to be combated. It set the asylum apart from the community, and to a certain extent even promoted that “isolationism” which was so vehemently criticized by S. Weir Mitchell in 1894,³⁷ and which had its effect on the hospital personnel. It placed the sole responsibility of both administrative and medical management on the shoulders of the hospital superintendent. When the person carrying these responsibilities was versatile and competent, this led to excellent and efficient coordination of all the hospital functions, but under poor administrators and mediocre psychiatrists conditions were often correspondingly deplorable.

As these influences upon psychiatric treatment began to make themselves felt, rumblings of uncertainty and some confusion of issues were developing. Some questioned the efficacy of one form of treatment or another, doubt developed concerning the validity of the principles established by Rush, more and more disputes arose as the controversy over

³⁶ See Dr. Hamilton's chapter in this volume, especially pp 78-79

³⁷ S. Weir Mitchell, “Address before the Fiftieth Annual Meeting,” *Am Medico-Psychol Assn, Proceedings*, I (1895), 101

restraint reached its height. Hospital superintendents began to feel the need for exchange of ideas, discussion of controversial subjects, and the introduction of some clarity in regard to confusing issues. Thus the Association was formed.

When the thirteen superintendents met in Philadelphia on the 16th of October, 1844, they appointed a number of committees to report on what they then considered to be the most important psychiatric issues of the day.¹⁸ Sixteen subjects were chosen. On treatment *per se* two committees were appointed: one, under the chairmanship of Samuel B. Woodward, on the medical treatment of insanity, and another, headed by Amariah Brigham, on the moral treatment of insanity. When we compare the proportional representation of reports on treatment at that time with that of the last two or three years (see Chart I), we find that in 1844 only about one-eighth of the papers dealt with treatment, as contrasted to approximately one-third in the years 1942 and 1943. This, however, does not mean that the welfare of the patients was of less interest at that time—in 1844—than it is now—one hundred years later—but rather that plans for their welfare centered around other factors which were not superficially classifiable as treatment but which were, nevertheless, of profound importance as the framework necessary for the administration of proper treatment. Thus we find that the subjects to be reported on were as follows: restraint and restraining apparatus; the construction of hospitals; jurisprudence; the prevention of suicides; organization and a manual for attendants; statistics; the support of the pauper insane; asylums for idiots, chapels and chaplains; post-mortem examinations; comparison of treatment in hospitals with that in private practice; asylums for colored persons; provisions for insane prisoners; and causes and prevention of insanity.

In his 1844 annual report Woodward¹⁹ gave a description of the medical treatment practiced at that time; the methods he described he considered quite representative of the treatment practiced in all American hospitals, although "some depend upon *medicine* more than others." His report began with a discussion of the so-called "depletion" treatments—that is, bleeding, cupping and leeching, administration of cathartics and emetics; the influence of Rush was still strong at that time, although signs

¹⁸ *Am J Insanity*, I (1845), 256

¹⁹ *12th Annual Report of the Worcester State Lunatic Asylum* (Boston, Dutton and Wentworth, 1844)

of departure from it were beginning to appear. As far as bleeding and active cathartics are concerned, they were regarded as "not favorable in insanity as it rarely affords more than temporary relief and frequently induces marked injurious effects." Woodward advised particularly against bloodletting even in "mania," since its effect is at best only temporary and symptomatic and it "usually produces more harm than good." He quoted cases where "great excitement" was followed by a state of apparent dementia almost immediately after free bloodletting. Local bleeding by cupping and leeching was regarded more favorably, especially in cases of excitement, but again could not be relied upon "as a cure of the disease itself." A similar attitude was taken toward the practice of drastic purging, since it produced digestive disturbances that were often injurious and seemed only to aggravate the general condition of the patient. Small doses of calomel were considered useful as alteratives and laxatives. Tinctures of rhubarb and colocynth were also quite popular. In cases of melancholy attended by gastric symptoms Woodward advised the use of guaiacum, but again primarily as a supportive rather than a specific measure. Emetics in general were condemned, since they did not seem to be of much use in "relieving the symptoms of insanity."

By far the most popular remedies in active mania were the narcotics, since "the condition of the brain in that disease is not an inflammation but rather a high state of irritation." Woodward felt that some patients under proper conditions could be cured without narcotics, although it seemed to him that in the majority of cases the symptoms yielded more readily under their administration. Morphine and its derivatives were regarded as the most useful drugs. He cautioned against the use of large doses particularly in the early stages of mental disease and urged that patients be watched carefully for untoward reactions.

Another drug which was regarded with favor by some was stramonium. It was prescribed in mania and epilepsy, and cases are quoted in which the convulsions were suspended for months under the use of the tincture. Extract of conium was used particularly in melancholia, either alone or in combination with iron, quinine, or Fowler's solution. The most surprising and varied symptoms were considered to be effectively helped by these drugs. Neuralgia, vertigo, glandular tumors—the latter often "the size of a quart bowl"—were said to disappear quite suddenly under the use of these remedies. Camphor is mentioned as a drug that had been

popular, but had gone out of fashion. Woodward added, "Camphor will probably never again receive the enconiums which it has occasionally had in times past as a remedy for insanity" (which is of interest in relation to the recent popularity of metrazol).

One of the most popular drugs of the day both here and in Europe was the extract of hyoscyamus. It was used particularly in cases of excitement and sleeplessness. Woodward believed that its virtues were probably overrated, but in cases that did not require stronger remedies it was considered valuable. Nux vomica was used mainly as a stimulant, mostly in neurological conditions and in cases of "relaxation" of the muscular tissues or weakness. Veratrin and belladonna were used occasionally, but Woodward warned against some of the untoward symptoms that might develop. Stimulants in the form of ammonia, lytta, and aromatics were used in cases of languid circulation and were considered particularly good in "recent dementia" (the description of which suggests catatonic states). These drugs were considered useful when supplemented by warm baths, friction, and so forth. Counterirritants in the forms of blisters, setons, and issues were considered useful in some chronic cases, but Woodward was not especially impressed by their efficacy. Tonics, of which he mentions particularly quinine, iron, and nux vomica, were considered very good supplementary treatment. Continued warm baths were found to be very effective especially in acute mania and some cases of melancholy, and the wish was expressed that they be used more generally than was the custom. Mustard baths, salt water baths, and any other form of local bathing were also considered important adjuncts in the treatment of insanity. Woodward was quite definitely opposed to such drugs as valerian, asafoetida, and other so-called "nervines" which he considered as of no practical use.

Woodward urged that a good deal of attention be paid to the physical diseases frequently accompanying mental disturbances; he was of the opinion that these should be treated vigorously so as to build up the patient's resistance, thus indirectly promoting relief from the mental symptoms. A number of other factors were thought to favor the recovery from insanity. Early admission to a hospital was strongly advised, since all remedies both medical and moral were most effective in the more recent cases. Proper classification was very strongly urged. "Nothing could be worse than association of the curable and recovering with the violent, the driveling idiots, the outrageous and profane." In making this separa-

tion it was recommended that patients be classified in such a way "that mutual good may be imparted and that no one shall associate not only with those that can injure them physically but that are obnoxious to them."

Proper diet was considered as of prime importance, and, in contradiction to older views, considerable quantities of food, and well-balanced diets were recommended. As Woodward put it, "perhaps there has been no greater improvement in the treatment of the insane than in the matter of diet—the older notions of starvation being everywhere discarded and a good diet substituted." Good ventilation and, especially, proper temperature regulation were also considered of great importance.

The general feeling was that "the insane should never be idle." This was considered particularly important for two reasons: occupation was a means of expending the energy otherwise used for violence, excitement, and mischief, and through occupation the patient might be "withdrawn from the theme of his gloomy musings." Recreation and amusements in all forms, anything in fact that was "innocent in the way of relaxation may do good." Riding, walking, dancing, music were all considered as highly beneficial, and parties were arranged to bring about healthy social intercourse among patients and employees. Reading of selected books was advised as helpful, and a library for patients was stressed as an essential part of the hospital. Physical labor was thought to be useful in the treatment of all patients who could be employed, whether they were excited, depressed, or demented. A good many of them were used as farm laborers, others in the various shops. Finally, Woodward stressed the importance of religious exercises under the supervision and guidance of the hospital chaplain.

There was a general tendency, even in his discussion of the so-called medical treatment, to caution against too much reliance on drugs and surgery and to emphasize the benefits of occupation, diet, good hygienic conditions, and recreation. This was still more strongly stressed by Brigham²⁰ in an editorial written in 1847 on "Moral Treatment of Insanity." The opening paragraph defines this form of treatment as follows: "The removal of the insane from home and former associations, with respectful and kind treatment under all circumstances, and in most cases manual labor, attendance on religious worship on Sunday, the establishment of regular habits and of self-control, diversion of the mind from morbid

²⁰ *Am J Insanity*, IV (1847), 1.

trains of thought, are now generally considered as essential in the Moral Treatment of the Insane." As for the need for such treatment, Brigham went on to say "In the majority of cases of insanity the moral treatment is of more importance than the medical and we fear that we shall never avail ourselves of the full value of the former nor cease to do injury to patients by administering too much medicine." Furthermore. "That some cases of insanity require medical treatment, we believe, but we also believe that a large majority of the patients in lunatic asylums do not." Brigham's historical review stressed the fact that the principles established by Pinel and Tuke were not, even in 1847, being followed to the point of their maximum good; Brigham recommended the moral treatment outlined by Tuke as particularly valuable. This view was shared by others in his time and even earlier. Kraepelin²¹ quotes Neumann as having made the following statement in 1818: "It is high time that we should cease the search for the herb or the salt or metal which in homeopathic or allopathic doses will cure mania, deterioration, delusions or excitement. It will not be found any sooner than one will find pills which will make a great artist out of an ignorant lout or a well-behaved child out of a spoiled one." Leuret's *Du Traitement Moral de la Folie* was highly praised by Brigham; although some of Leuret's methods were considered extreme, most of them were recommended as valuable and practical. Instruction and amusement, rational discussions with the patients of their symptoms and their problems, mental occupations such as reading, games, and so forth, Brigham considered highly beneficial. Occupations of an absorbing type, those requiring a certain amount of mental ingenuity and leading to creative results, were considered more helpful than the more menial labor on a farm. The proper training of the staff and attendants to encourage patience and humane treatment instead of intimidation and punishment was emphasized as an important factor in Brigham's program.

It must be emphasized that the sane, cautious words of Woodward in regard to medical treatment and the lofty ideals expressed by Brigham were probably not fully accepted by the majority of then practicing psychiatrists, either within or outside of hospitals. Still less were they actually followed. The Original Thirteen were well aware of the general disfavor or apathy shown such methods of treatment; one of the chief functions of the early Association was to spread these views and to secure

²¹ E. Kraepelin, *Hundert Jahre Psychiatrie* (Berlin, Springer, 1918).

their general acceptance. In another direction, we find occasional scattered suggestions, both at the early meetings and in the general literature, of new methods of using already acquired knowledge and of attempts to abandon old traditions that had proved injurious. Every now and then we come across the phenomenon of some hitherto unused method developing into a fad, which then either was accepted for use in moderation or died out altogether if experience proved it to be useless. Thus, for instance, we find at the annual meeting in 1853 a discussion of the practice of etherization.²³ Even then the dangers of the treatment were pointed out, but the discussion was continued at the next four or five meetings (see Charts I and II), gradually thereafter to be dropped entirely along with the use of other anesthetics in the treatment of mania.

For a number of years following the foundation of the Association, a great deal of discussion, at times quite heated, took place on the controversy of restraint vs. nonrestraint. There is no question but at that time, as was already mentioned above, there were a good many logical arguments on both sides. Actually we must admit that, until the introduction of more modern psychotherapeutic and hydrotherapeutic techniques, the complete abolition of restraint seemed hardly feasible. Interestingly enough, many of the hospital psychiatrists who opposed the abandonment of restraint rarely used it in their own hospitals.²⁴

Along with the treatment of those already sick, a great deal of thought was given to the study of methods of prevention. Even in his writings before 1844 Woodward²⁵ spoke of the value of education and proper upbringing in the prevention of mental diseases. Isaac Ray's presidential address in 1858 was entitled "Mental Hygiene,"²⁶ and in his talk as well as in a paper by Cook published under the same title²⁷ some very pertinent statements were made about the value of certain preventive measures, particularly in the parent-child relationship. Throughout these early years we also find progress in the development of a number of other procedures. The use of hydrotherapy, particularly as modified by the follow-

²³ Isaac Ray, "On Undescribed Forms of Acute Maniacal Disease" (Discussion), *Am J Insanity*, X (1853), 80

²⁴ H. P. Stearns, "Progress in the Treatment of the Insane," *ibid*, XLI (1884), 22

²⁵ S. B. Woodward, "Errors of Education", "Management of Children." *Collected Writings*, Vol. 3, Worcester State Hospital

²⁶ Ray, "Mental Hygiene," "Proceedings" of 13th Annual Meeting, *Am. J. Insanity*, XV (1858), 122.

²⁷ G. Cook, "Mental Hygiene," *ibid*, XV (1859), 272

ers of Priessnitz,²⁷ judicious application of massage and other physiotherapeutic measures, and the importance of diet received serious attention; their application was improved upon in keeping with new developments in chemistry and physiology.

The general attitude toward the use of drugs also underwent changes. Instead of the indiscriminate acceptance of drugs on the basis of tradition, we find reports on scientific investigations to determine their actual effects. This was particularly true in the case of newly introduced drugs. The most important and popular ones were such drugs as *Cannabis Indica* reported on in 1859,²⁸ *Bromides* as used in epilepsy²⁹ and *Digitalis* in the treatment of mania.³⁰ *Chloral Hydrate* was first reported on in 1870,³¹ and its introduction marks an important development in the pharmacotherapeutics of mental disease. It was the first valuable synthetically produced sedative and hypnotic to find popular application in the field. In a way it may be regarded as the first of a series of such drugs, which with the discovery of the barbiturates, particularly sodium amytal, led to a very useful combination of drugs and psychotherapy. At the same time, however, it brought in the dangerous practice of using such drugs as substitutes for mechanical restraint.

It was throughout this early period too that much discussion took place on the subject of classification—that is, the separation of the chronic from the acute cases, which ultimately had an important effect upon some phases of treatment. The question of separate hospitals for the chronic patients caused a great deal of discussion at the meetings, and in spite of the intense reaction on the part of a good many leaders in the field such hospitals finally were built.³²

Another trend which developed as an effort to cope with this problem was the boarding out or “family care” system.³³ About this time, too,

²⁷ J. H. Kellogg, *Rational Hydrotherapy* (Historical section) (Battle Creek, Modern Med. Pub. Co., 1923)

²⁸ J. P. Gray, “On the Use of *Cannabis Indica* in the Treatment of Insanity,” *Am. J. Insanity*, XVI (1859), 81.

²⁹ “Proceedings” of the 19th annual meeting, discussion by Curwen *et al*, *ibid*, XXII (1865), 64.

³⁰ Richard Gundry, “Report on Use of *Digitalis* in Mania,” *Ibid*, p. 74.

³¹ T. S. Kirkbride, “Report on Use of *Chloral Hydrate*,” discussion, “Proceedings,” *Ibid*, XXVII (1870), 210.

³² For a full discussion of this development and of the ensuing colony or cottage system, see Dr. Hamilton's chapter in this volume.

³³ See Dr. Hamilton's chapter.

developed the practice of sending out on furlough or "visit" certain properly selected patients. This was first reported on in 1876.⁸⁴ Efforts along these lines were not altogether new, as Kirkbride pointed out in his discussion of the report, but the resurgence of interest in these procedures led to their spreading to many hospitals and they have proved to be, even to the present time, of great value in the readjustment of patients as well as effective in reducing the congestion in hospitals.

It is interesting to follow the rise and fall of enthusiasm in regard to any special trend in the field, whether directly or indirectly concerned with treatment, and the parallel rise and fall in the enthusiasm with which the workers went about their tasks. This is clearly seen in the history of the "cult of curability," which has been referred to above. We saw there how it influenced both psychiatry and the lay public and was responsible for the construction of hospitals early in the existence of the Association. As the profession became entrenched in its institutions and began to take stock of its available techniques of treatment and actual achievements, the wave of criticism against unwarranted optimism began to grow and the real facts came to light. Poor statistics, sometimes amounting to definite falsification, misrepresentation of minor and temporary improvements as actual recoveries, and similar manipulation of reports were discovered and were subjected to severe criticism.

One of the most vigorous and capable critics of this cult was Pliny Earle who, on the basis of a series of investigations, finally succeeded in exploding the myth in the late eighties.⁸⁵ His analysis had a far-reaching effect upon the whole course and progress of the psychiatric treatment of the time. It must be remembered that the enthusiasm for announcing a high percentage of cures developed on the basis of the actual improvements in treatment introduced by the exponents of moral treatment. Even if the effects of this treatment were exaggerated, there is no question but that the good it did definitely exceeded the effects of the haphazard medical treatment of the early days and certainly was an immense improvement upon no treatment at all. In a measure, as the belief in a high proportion of cures fell, it dragged down with it the faith in the efficacy of moral treatment and naturally lessened the emphasis on emotional and socio-psychological factors as causative of mental diseases. The statement, for instance, made by Brigham in 1843 that "with Pinel, Esquirol and

⁸⁴ R. F. Baldwin, "Furloughing Patients," "Proceedings," *Am J Insanity*, XXXII (1876), 293.

⁸⁵ Deutsch, *op cit*, p. 155.



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Georget we believe that moral causes (acting through emotions, passions and sentiments) are far more operative than physical" was considered by Gray when he quoted it in his report of 1871²⁶ as being untenable in the light of his own findings. Gray remarked that the statistics at the Utica State Hospital for 1870 showed that 85 per cent of mental diseases were ascribed to physical causes, and none to moral. As a natural parallel to this change in orientation, and perhaps as a concomitant to the wave of materialism that was invading psychiatry as well as the biological sciences in general, we find a shift of interests not only in treatment but in psychiatric research, away from the individual patient toward isolated, organic investigations.

Another factor of this period which exerted an important influence on developments in psychiatry was the progressively increasing tendency toward the specialization of psychiatric hospitals and their separation both from the community and the field of general medicine. As was pointed out above, the strong influence of the York Retreat on early American hospitals encouraged the development of certain aspects which were undoubtedly of help in the days of Tuke, but became unnecessary or even deleterious later on. At the time insane patients in the community were relegated to the poorhouses or jails, the building of special hospitals such as the Retreat was urgently needed. When the private practitioner was treating mental diseases by "depletion" and pills, moral treatment was by far the method of choice, and it could best be developed by special training and work in the proper institutions. Now, however, as medical science was developing and certainly had a great deal to contribute to the physical treatment of the insane, the isolation of psychiatry was distinctly a disadvantage. Yet psychiatry was gradually insulating itself in the so-called "monasteries of the mad." This, of course, was not true of psychiatry in the hands of all psychiatrists. There were outstanding men such as Bell, Kirkbride, Earle, Ray, and following them, Cowles and others who carried on progressive work in psychiatry, not only through their own investigations but also by keeping abreast with developments in the social and biological sciences. Such men were definitely in the minority, however. Most psychiatrists did very little individual clinical work and practically nothing in scientific research. It was not by any means a matter of choice in a great many cases. The institutions were

²⁶ Gray, "The Dependence of Insanity on Physical Disease," *Am. J. Insanity*, XXVII (1871), 377.

usually understaffed, the administrative work had to be looked after, and the management of the patients and their general care was enough to keep everyone busy. These were not conditions conducive to progress in any phase of the work, including treatment.

Conditions of this kind could not help but lead to dissatisfaction within and criticism from without, and perhaps one of the most powerful sources of the latter was found in the newly developed, younger sister of psychiatry—neurology. This specialty in medicine was largely an outgrowth of experiences in the Civil War.⁸⁷ Up until that time neurology, if it was practiced at all, was either part of general medicine or a collateral of psychiatry. The organic neurological disturbances that developed during the war on the basis of trauma, infection, and so forth, and the neuroses which were bound to develop under stress of war, had attracted the attention of a good many general physicians in the army and some of them developed so much interest in the work and such appreciation of its importance that they continued in it after the war was over. As the neurologists came in contact with clinical psychiatric material and psychiatrists, rivalry developed between the two from the start. The psychiatrists looked upon the neurologists with mistrust and regarded them as upstarts who had not had the proper training and experience to deal with psychiatric problems. The neurologists, on the other hand, considered their rivals as reactionary, unscientific, and primarily business executives. In their search for new points of view and adequate training, some of the neurologists turned to Europe, where a great deal of work was being done in neurophysiology, neuropathology, and clinical neurology. From the clinics of Meynert, Charcot, and others, they brought back more knowledge and in some cases an urge to reform not only neurological practice but also that of psychiatry. To a certain extent these new ideas did infiltrate psychiatry, since the ebbing of the enthusiasm for "moral treatment" provided fertile soil for them to take root.

As could be expected, they had their strongest effect upon the younger generation. At about that time a change took place in the Association the effect of which can well be seen in Chart I. Until 1885 the membership of the Association was limited to superintendents. Gradual recognition of the fact that attendance at the meetings, presentation of papers, and participation in the discussions would be beneficial to the other members

⁸⁷ See also Albert Deutsch's chapter on "Mental Hygiene"; also, his section on the Civil War in the chapter, "Military Psychiatry."

of the various hospital staffs led to the admission of assistant physicians to membership in 1885.³⁸ The rise that almost immediately became evident in the number of papers presented at the meetings can be seen in the chart, but it is also apparent that the interest of this new group was not in treatment but in investigative work, primarily pathology, physiology, and pharmacology. At the same time, and perhaps for the same reasons, medical and surgical procedures began to influence the treatment of insanity. At first there was a strong tendency toward the development of fads and the introduction of certain isolated procedures as panaceas for all ailments. Some of these stand out particularly vividly. One example was a wave of popular interest in the surgical treatment of mental diseases. It started out conservatively enough with trephining in epilepsy. Very soon, however, general surgery was being recommended in different types of mental diseases, including the use of trephining in other types of cases. The peak of this trend was reached about 1892;³⁹ at the Association's annual meeting that year a number of outstanding men including Blumer, Wagner, and others engaged in a general discussion of the subject of surgical treatment, not only of epilepsy but of insanity in general. As might be expected, the advocates of wide-scale treatment of mental diseases by such procedures did not achieve much. The interest aroused, however, succeeded in introducing properly controlled surgical procedures into mental hospitals, construction of surgical rooms, training of personnel, and introduction of modern methods, as it finally settled down to the logical recognition of the need for modern surgical treatment for conditions that warranted it.

Another trend of the day was the introduction of endocrine treatment. In this we find again an example of the influx of new blood from the field of general medicine and neurology. The introduction of endocrine treatment took place shortly after the discovery of the relationship of the thyroid gland to cretinism and goiter. In 1887 we find a paper by C. K. Clarke⁴⁰ on the relationship between goiter and insanity. Almost immediately the endocrine movement mushroomed into a full-blown fad. Very little was known at that time about the diseases of the thyroid, and still less about properly controlled thyroid medication or surgery, but there was a general and rather indiscriminate application of such treatment,

³⁸ "Proceedings" of the Association of Medical Superintendents, *Am J. Insanity*, XLII (1885), 60

³⁹ "Proceedings" of the Association of Medical Superintendents, *ibid*, XLIX (1892), 222

⁴⁰ "Goitre and Insanity," "Proceedings" of the Association, *ibid*, XLIV (1887), 90

and there were all kinds of enthusiastic reports about the excellent results. During the next few years we find frequent reports on this type of treatment in all kinds of diseases, even including operation on the thyroid in cases of catatonia.⁴¹ In 1898, however, the general discussion of a paper by B. W. Stone⁴² pointed out that thyroid medication not only was not generally helpful but, when used indiscriminately, was actually injurious and even dangerous. Such discussion, of course, did not entirely eliminate thyroid therapy, but it led to the limiting of such therapy to actually demonstrated thyroid deficiencies or dysfunctions. It was not until a few years ago that a more general type of endocrine therapy of mental diseases was again revived.

These are only two examples of a number of somatically oriented developments that appeared during this period. In the meantime, and as a stable background to these new ideas, previously established methods of treatment were practiced and frequently modified in keeping with needs as they arose. Moral treatment in the form of efforts to adjust the patients satisfactorily to the hospital situation, discussions of their problems with them, liberal use of hydrotherapy, occupational therapy, and outdoor work were continued with good results. A great deal of progress was also being made in reducing the use of mechanical restraint as much as possible. All these forms of treatment, however, were carried on more as a matter of tradition while the newer, more organically oriented methods occupied the center of the stage. Discounting the inevitable cropping up of fads of one kind or another, there were some very good results from the use of these newer methods. The practice of good medical and surgical procedures made its way into some of the hospitals and had its effects not only upon the physicians but upon the rest of the personnel. One of the most important steps in the progress of psychiatric treatment was the establishing in 1882 of the first nurses' training school in a mental hospital, at the McLean Hospital. Other hospitals followed this example and it is hardly necessary to stress here the importance of this development in the care and treatment of the mentally sick.⁴³

In his review of the progress in psychiatry during the first fifty years of the existence of the Association, Cowles⁴⁴ emphasized strongly the impor-

⁴¹ H. J. Berkley and R. H. Follis, "Thyroidectomy in Treatment of Catatonia," *Am Medico-Psychol Assn, Proceedings*, XV (1908), 283.

⁴² B. W. Stone, "Thyroid in Insanity," *ibid.*, V (1898), 174.

⁴³ See Dr. Bunker's chapter, "American Psychiatry as a Specialty."

⁴⁴ E. Cowles, "Progress during the Half Century," *Am J. Insanity*, LI (1894), 10.

tance of what he called the "systems of new psychology" in bringing about advances in the understanding and treatment of mental diseases. He quoted a publication by Van Deusen in 1868 entitled "Observations on a Form of Nervous Prostration (Neurasthenia) Culminating in Insanity." Cowles made a point of the fact that this paper was published before the appearance of Beard's original paper on neurasthenia, and added that "even the neurologists are not yet agreed as to the existence of such a disease." Cowles furthermore emphasized that Van Deusen made his observations at the time he was working in the Utica Asylum and published the material when he was Superintendent of the Kalamazoo Asylum. Cowles felt that Van Deusen's contribution was important because some psychiatrists were already beginning to feel that the fatigue of the nervous system in neurasthenia is the starting point of a great many forms of insanity. He went on to say that even if this theory could not be accepted in toto, it would have to be agreed that the syndrome represented in nervous weakness which is common to most mental diseases; therefore, the so-called "rest" treatment which had been devised for this condition might well be indicated in other more general psychiatric conditions. In other words, Cowles felt that, at that time—one hundred years after Pinel and Tuke—"we have come to see again the wisdom" of their therapeutic efforts in dealing with mental diseases. This point of view, expressed at a time when psychotherapeutic efforts had been largely displaced by an enthusiasm for organic methods of approach and somatic emphasis in general, may be regarded as that thread which preserved the contact between the moral treatment of earlier days and the psychotherapies developed in the twentieth century.

In the meantime, other trends were developing which influenced the future of psychiatric treatment as well as other aspects of psychiatry. One was the organization of psychiatric teaching in medical schools, and the subsequent appearance of adequate textbooks.⁴⁵

Also, an event must be mentioned which in itself was not too important but which was a manifestation of an underlying process that significantly influenced contemporary and future developments. Reference has been made to the fact that in 1885 assistant physicians, with certain qualifications, were declared eligible for admission into the Association. Nevertheless, the name of the Association remained unchanged; it was still "The Association of Medical Superintendents of American Institutions

⁴⁵ See Dr. Bunker's chapter, "American Psychiatry as a Specialty."

for the Insane." One cannot help but feel that as long as this was so the assistant physicians must have considered themselves to some extent outside of the inner circle. Furthermore, the name automatically tended to shape the Association's policies to coincide primarily with the needs of the superintendents. Many of these superintendents, it is true, had shown outstanding ability and interest in investigative work. The publications of such men as Earle, Workman, Bell, Ray, and Brigham extended far beyond the administrative field. But such men were few, and as time went on and new blood came into the Association a point was reached when its name and, what is more important, its policy had to change. At the instigation of such men as Cowles, Hurd, and Stearns and after prolonged discussions, the name was finally changed to that of "The American Medico-Psychological Association", at the 46th annual meeting in 1892.⁴⁰ It is interesting that at that meeting Hughes, of St. Louis, proposed that the new name be "The American Psychiatric Association"; his suggestion was not accepted because "that name, especially to the laymen, would be a very embarrassing one to translate." Hurd's discussion on the subject is illuminating: "In the past, the Association has been very largely composed of asylum superintendents, of men who were here simply because they were superintendents of asylums. This was extremely important during the constructive era of American asylums . . . the time has come when its members should not only be superintendents and managers of asylums but foremost in psychological work. . . . It is desirable, not only that the members should be fit to manage an institution but also . . . competent to investigate the problems which come up in connection with the treatment of those diseases." Herein lies the actual reason for a change in name which, to judge from the rest of the discussion, was accepted by the "foremost" men of that day, most of whom incidentally were superintendents. There is no doubt but that this change, and particularly the resulting change in policies, allowed the younger men a greater participation in discussions and stimulated them in their work with patients.

The cross-currents of trends described above which ushered in this new period in the life of the Association came to a rather dramatic climax at the 1894 meeting, they were particularly reflected in the annual address delivered by S. Weir Mitchell and the reaction of the members of the Association to it. It speaks well for our predecessors of that day that,

⁴⁰ "Proceedings" of the 46th Annual Meeting, *Am J Insanity*, XLIX (1892), 128.

having recognized their most important immediate needs, they invited Mitchell to deliver this address and persisted in the invitation even after his original reluctance to accept it because "he felt that if he spoke at all, criticism rather than compliment must predominate in his remarks."⁴⁷ True to his word, he proceeded to express his views in terms free of any pretense and at times biting in their condemnation. Mitchell's address was not limited to criticisms but proceeded to outline positive recommendations. Although some of these were helpful and constructive, others showed a lack of knowledge of the existing problems and the real obstacles to their solution.⁴⁸

This address unquestionably reflected the attitude of neurologists toward psychiatrists at that time, and the reaction of the members of the Association to it should be gratifying to the present-day psychiatrist. Of course several felt resentful. Channing's reply in writing⁴⁹ probably represented the sentiments of a good many of his colleagues. He accepted with grace the justifiable criticisms but pointed out clearly the mistakes made by Mitchell. However, the general reaction of our predecessors showed that they not only could "take it" but were willing to come back for more. They were receptive and anxious to profit from well-founded criticism and constructive suggestions. It is to the everlasting credit of the members of the Association that following such an experience they had the courage and wisdom to seek further advice from similar sources. Seven out of the eight next annual addresses were given by outstanding neurologists of the day. Furthermore, the events that immediately followed the meeting in 1894 certainly showed a wholesome resolve to benefit from such criticism.

The founding of the Pathological Institute of the New York State Hospitals in 1895 was the first of a series of developments that had a profound effect upon the progress of research in general and treatment in particular.

The changes that followed were not, of course, entirely or even primarily due to the S. Weir Mitchell address. Certain events which occurred even before that had gradually prepared the ground. The end of the nineteenth century, significant as it was in the development of the scientific and experimental approach in all fields of science, did not pass

⁴⁷ "Proceedings" of the 50th Annual Meeting, *ibid*, LI (1894), 100

⁴⁸ S. Weir Mitchell, "Address before the Fiftieth Annual Meeting," *Am Medico-Psychol Assn, Proceedings*, I (1895), 101 See also Dr Whitehorn's chapter, pp 167-168

⁴⁹ W. Channing, "Some Remarks on the Address by S. Weir Mitchell," *Am J Insanity*, LI (1894), 170.

without its effect on psychiatry. Kraepelin introduced clarity into the tangled chaos of psychiatric thought, even though this may have been at the expense of more profound understanding. His Linnaeus-like system of classification—even though it was primarily descriptive and symptomatological rather than based on an understanding of the nature of the diseases, as was emphasized by Bleuler, or of their psychological dynamics, as was stressed by Freud—did provide a sorely needed frame of reference for the systematic application of treatment to distinct disease entities, and it served as a foundation for a host of investigative works. Kraepelin's experimental work also helped in introducing scientific methods into the field. His co-workers, particularly Nissl and Alzheimer, were just beginning to apply exact methods in histopathology and Nissl, working in collaboration with Kraepelin, began a search for organic factors in the causation of mental disease. About this same time, too, systematic work was begun on the psychological dynamics of mental diseases by Janet in France and Freud in Vienna. Finally, the effects of contemporary psychology began to become apparent in psychiatric thought. Stanley Hall, William James, and Boris Sidis—to whom White attributed an especially important role in influencing psychiatric thinking in this country—all tended to stimulate investigations in the search for a better understanding of the nature of mental diseases and more scientific approach to their treatment.⁶⁰

It must be emphasized that the Kraepelinian system of classification and the search for an organic background for mental disease had an important influence on the minds of most psychiatrists; in the first few years of the second half century of the Association we find many attempts at classification by clinicians and pathological research among the investigators. Treatment in this era consisted either in carrying on newer versions of old methods or in an accentuation of the tendencies to introduce general medical and surgical methods into psychiatry. Along with the development of good nursing care, physicians began to apply modern knowledge and techniques to the somatic needs of their patients. The stethoscope and the thermometer began to be used more freely and adequately, surgery had found its logical application to certain organic diseases occurring among the insane, and more adequate dietary and hygienic conditions were instituted in the hospitals.

Gradually, however, observers began to recognize that mental diseases

⁶⁰ Zilboorg, *op cit*; White, *op cit*; B. Hart, *Psychopathology* (Cambridge, University Press, 1939).

must be regarded as abnormal reactions of individuals to their human needs, in relation to their social setting; as this recognition grew, it brought with it new attitudes in regard to treatment. The two most important contributors in this direction were Adolf Meyer and William A. White.

When the Institute in New York was founded, Ira Van Gieson was appointed its Director, and in keeping with the trend of the time and his particular interests and training he directed most of the efforts of the Institute into pathological-anatomical studies. In 1902 he was succeeded by Adolf Meyer, and although Meyer began his career and made most of his earlier contributions in the field of pathology, he brought with him to the Institute a wide interest in human beings which reached beyond the laboratory into their life histories, social settings, and general human needs. Early in his career in New York, he began to stress the importance of understanding mental diseases as reactions to life situations, and to emphasize the necessity of taking into consideration all phases of the patient's contacts, biological as well as psychological and social. For this purpose, it was necessary not only to know the patient's present condition but also to have information concerning his family history, his social setting, and his own life history. This necessitated a host of co-workers who would be able to go out into the community and gather these data, and who could later use this information to readjust the patient to the community. In this way psychiatric social work came into being as a necessary and integral part of psychiatric treatment. The influence of Meyer on psychiatric thought in general, and especially in regard to treatment both during hospitalization and after, was one of the most important factors in the progress of psychiatric treatment for years thereafter. His influence was particularly effective through the medium of personal contact in his teaching at medical schools and in post-graduate training of specialists in the field.²¹

William A. White's point of view and contributions were perhaps more definitive in their scope.²² During his training period in psychiatry he had come into contact with Boris Sidis and had experimented with him in the field of psychological motivations. Always curious and analytical, he searched for underlying factors in the development of abnormal

²¹ A Meyer, "Objective Psychology or Psychobiology," *J A M A*, LXV (1915), 860; W. Muncie, *Psychobiology and Psychiatry* (St Louis, C V Mosby, 1939)

²² William A. White, *Outlines of Psychiatry* (13th ed., Washington, Nerv and Ment Disease Pub Co., 1932).

reactions and naturally came under the influence of psychoanalysis. He also had a great interest in general medicine, which he had acquired even before entering the field of psychiatry. In addition White was acutely aware of the problems and peculiar needs of state hospital administration, through his earlier experiences in the Binghamton State Hospital and later in St. Elizabeths. His was a versatile mind as keenly interested in sociological problems as they applied to psychiatry as in the need of a properly constructed hospital for the care and management of patients. He was quick to pick up new methods of treatment and introduce them into his own organization, as well as to secure their acceptance in the psychiatric profession. White's close contact with general medical practice made him appreciate and preach the necessity for adequate treatment of the patient's somatic needs. Most important of all, however, was his influence in the teaching and practice of psychotherapeutic methods of treatment, which he exercised through the medium of personal contact but, to a larger extent, through his prolific writings marked by clear-cut exposition and facile modes of expression.

The influence of William A. White and Adolf Meyer and their co-workers in the field of psychiatric treatment can hardly be described as limited to any special method or as applicable to any particular form of mental disease. Their greatest contribution lies in the comprehensiveness of their efforts. From that point of view they can be considered as constituting a link between the work of the early pioneers and the methods that are in use at present. From the beginning Meyer stressed the importance of thorough somatic therapy as an integral part of whatever psychotherapeutic measures were being taken. Adequate diet, rational occupational therapy, and recreation were instituted by Meyer and his co-workers at the same time they approached the social and psychological problems of the patients and tried to help them solve these problems. At the same time, Meyer vigorously championed adequate follow-up and after-care of the discharged patients. The whole orientation of the psychobiological approach and distributive analysis depends for its efficacy on the fact that in the treatment of the patient one must consider him in all his activities as a social and biological organism, with therapeutic efforts to be undertaken wherever a problem exists. No one facet of the organism is necessarily any less important than any other. White, too, while he stressed the psychoanalytic method of treatment more strongly than others, emphasized suitable hospital conditions and adequate social

research for each individual patient as a necessary element of any attempt at treatment.

It is difficult to imagine how our modern methods, most particularly the various psychotherapeutic ones, could have gained their present solid footing without the influence of these two men. Finally, we must stress their influence upon the psychiatric profession in turning its interest toward extramural and community problems. The contributions of White to the understanding and treatment of legal problems, his and Meyer's emphasis on preventive psychiatry, the treatment of children and juveniles, all served to lay the foundation for the developments that began toward the end of the first decade of the twentieth century.

In the meantime a good deal was being done in perfecting some of the important auxiliary methods which had originated in earlier years but were now receiving much attention from leading men in the field. Hydrotherapy was gradually being systematized and placed on a more scientific basis. In a paper presented in 1902 on hydriatic procedures in the treatment of insanity,⁵³ E. C. Dent, Superintendent of the Manhattan State Hospital, justifiably emphasized the importance of this form of treatment and made a plea for its more rational and scientifically controlled application. Dent gave due credit to the earlier attempts such as those of Priessnitz of Austria in 1820 but also brought out that since then a great deal had been done to remove from hydrotherapy the stigma of punishment. He pointed to the unreasonableness of some of the earlier methods by means of which, under the pretext of psychological effect, various barbaric tricks were practiced upon the patient. Dent stressed the important work that was being done by Simon Baruch in New York in regard to rational hydrotherapy in various forms of diseases and urged the use of the tub, the spray, and the douche as applicable to various types of behavior disturbances.

Occupational therapy, too, was becoming more systematically organized. In 1898⁵⁴ Hoyt reemphasized the point made earlier by Brigham, that in prescribing such treatment more attention should be paid to the needs of the patient than to those of the hospital. Hoyt urged the development of more creative work of the kind that could absorb the interests of patients, in preference to the hospital's being guided primarily by how

⁵³ E. C. Dent, "Hydriatic Procedure as an Adjunct in the Treatment of Insanity," *Am J Insanity*, LIX (1902), 91.

⁵⁴ F. C. Hoyt, "Occupation in the Treatment of the Insane," *Am Medico-Psychol Assn, Proceedings*, V (1898), 288

much help the farmer needed to produce a crop or to look after the cattle.

In the use of drugs at this time, we find a rather deplorable tendency insidiously making its way into most state hospitals. It must be remembered that the problems of restraint had not as yet disappeared altogether. In fact, outside of a few of the cruder methods that were in vogue early in the nineteenth century, one or another form of restraint was still in widespread use. Mention has already been made of the fact that White, upon his assumption of duties at St. Elizabeths, found the "saddle" still being used there. When the fight against mechanical restraint became particularly vehement and the hospitals found themselves forced to give up a good deal of it, the pernicious habit of replacing it with chemical restraint developed freely. In recounting his experiences Campbell⁸⁸ told of visiting some hospitals where the daily rounds of some of the physicians consisted largely of going about with syringe and hypodermic needle and indiscriminately giving injections of sedatives and hypnotics to patients standing in line with sleeves rolled up ready to receive their daily dose of chemical restraint. In looking back, Campbell wondered whether it would not have been more humane and less injurious to some of them, at least, if they had been placed under some form of physical restraint. It was only years later that psychiatry began to awaken to the injurious effects of such practice, and such an awakening occurred only when psychiatrists came to realize the great value of some psychotherapeutic attempts and rational occupational and hydro-therapy as the logical replacements of restraint.

About the end of the first decade of the twentieth century a series of important developments took place which left a lasting effect upon the progress of treatment in psychiatry, and which really made possible the great developments that followed immediately after the conclusion of the first World War. One of these, the development of modern methods in the treatment of general paresis, stands out as a most fascinating chapter in the history of treatment. The early work of Nissl and Alzheimer and of a number of investigators in this country who followed them succeeded in proving beyond doubt the organic nature of this disease and in establishing the histological picture that is characteristic of it. This inevitably made people curious as to the nature of its etiology. Although sporadic attempts had been made to link it up in one way or another with syphilis, there seemed to be an almost fanatical resistance on the part of

⁸⁸ C. M. Campbell, Personal communication

some of the most eminent men of the time against such a hypothesis. The early ideas of the relation of general paresis to alcoholism and a generally dissolute life still persisted strongly in the minds of some, but even when the idea of an infectious agent began to be universally accepted, investigators still looked for some special organism other than that of syphilis as the cause.

One of the most intriguing theories was that brought forth by W. Ford Robertson of Scotland in his Morrison Lecture for 1906.⁵⁶ He stated that paresis was caused by a specific bacillus, which he called "bacillus paralyticans," belonging to the diphtheroid group, which gained access through the respiratory and alimentary tracts; the "bacillus paralyticans" was actually isolated and demonstrated by Robertson in various tissues of the body. He went on to state further that syphilis, alcoholism, and dissipation could only be regarded as contributory factors in breaking down the general defenses. This theory gained many adherents in this country. Langdon of Cincinnati presented a paper at the meeting in 1906, agreeing with the general findings and stating that he had found the bacillus in the cerebro-spinal fluid.⁵⁷ A number of other men took up the work, and in 1907 O'Brien⁵⁸ presented a paper on the treatment of the disease by the use of opsonins as a specific against paresis. However, many people were skeptical, including Southard,⁵⁹ who questioned the etiologic significance of the bacillus paralyticans.

The introduction of the Wassermann test and particularly the demonstration by Noguchi and Moore in 1913 of the presence of the spirochete in the brain immediately placed the treatment on a sound footing; specific antiluetic treatment was inaugurated, and reports of the results began to appear⁶⁰ both at the meetings of the Association and in the general literature. The Swift-Ellis treatment was preferred by some, others were using mercury and iodides; for the next few years hardly a meeting was held at which this problem was not discussed in one form or another.

The actual results achieved by treating general paresis with chemo-

⁵⁶ W. Ford Robertson, "The Pathology of General Paralysis of the Insane," *Rev Neur and Psychiatry*, Feb, March, April, 1906

⁵⁷ F. W. Langdon, "Paresis: a Research Contribution to Its Bacteriology," *Am Medico-Psychol Assn, Proceedings*, XIII (1906), 153

⁵⁸ J. D. O'Brien, "Opsonins in the Treatment of Paresis," *ibid*, XIV (1907), 221

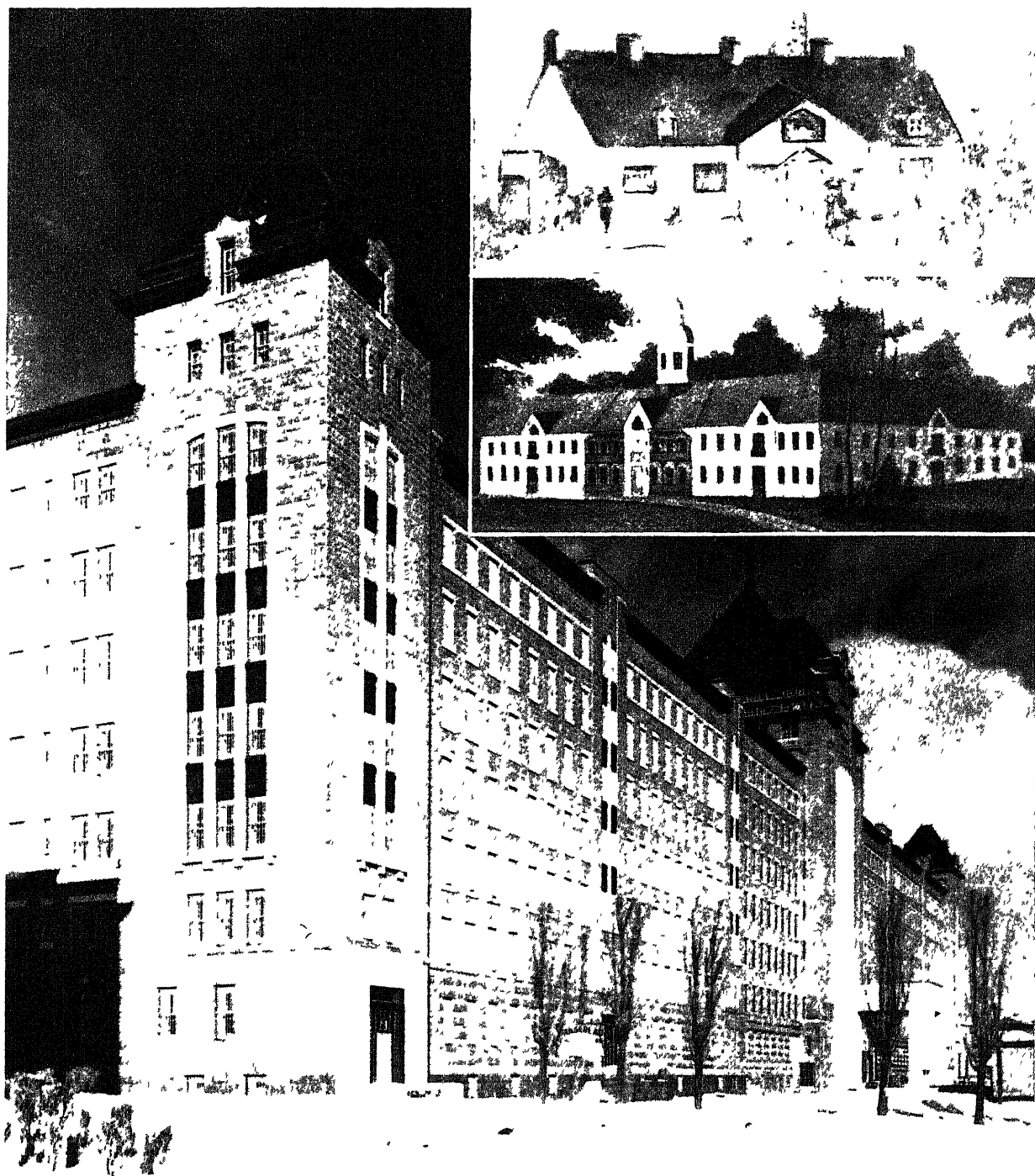
⁵⁹ E. E. Southard, in a discussion on a paper by J. D. O'Brien, *ibid*, XV (1908), 143

⁶⁰ "Symposium on General Paralysis" (T. W. Salmon, C. B. Dunlap, A. Meyer, D. M. Warner), *ibid*, XXI (1914), 175-213.

therapy were not too effective in combating the disease. Nor was the efficacy of the treatment at all comparable with that of the present time. The important thing was that for the first time in the history of psychiatry there had been discovered the etiology of a mental disease occupying an important place by virtue of its numerical proportions, as well as a specific drug which could be used even though its efficacy left much to be desired. This provided a stimulus and inspiration for research on other forms of mental disease and, even if these investigations did not result in any great therapeutic contributions except to the syphilitic psychoses, they have added a great deal of knowledge in the field of neuropathology. One of the most prolific workers in this field was E. E. Southard, who was as great an investigator as he was a teacher. The work done by his group was mainly along the line of research.²¹ Its influence on progress in therapy, however, was of importance in setting adequate standards for objective logical thinking and serving as a counterbalance against Icarian flights into fantasy.

A second trend that began to gain momentum in this country at about this time, although it did not reach its full proportions until after the War, was the psychoanalytic movement with its influence on intra- and extramural therapeutic work. This is not the place to go into the wide ramifications of the history of the psychoanalytic movement, even if they were limited only to this country. Some mention must be made, however, of certain aspects of psychoanalysis, since its development had a profound influence on the present status of psychotherapy in its broad implications, on child guidance, mental hygiene, criminology, and psychosomatics. Although Freud's first publication on this subject appeared early in the nineties, psychoanalysis spread rather slowly in Europe and it was not until some time after the beginning of the twentieth century that its effects were noticed here. At first it was received skeptically, even antagonistically, but as the clinic at Burghölzli began to attract the younger men, drawing them away from the Kraepelinian influence, these men were brought into contact at least indirectly with psychoanalytic thought around 1906 and 1907. One of these men was A. A. Brill who, upon his return here, started his great work of disseminating Freud's writings in this country through translation; in addition he made his own contributions to psychoanalysis.

²¹ See Dr. Whitehorn's chapter.



MANOIR DE BEAUPORT (HÔPITAL ST. MICHEL ARCHANGE)

1845 • 1850 • 1943

In 1909 Freud was invited to America by G. Stanley Hall and J. J. Putnam, and through his lectures⁸² and the personal contacts he made his influence soon began to spread. Meyer, in his capacity as leader in psychiatric thought in America, even though he had never wholeheartedly accepted the theory or even the method of psychoanalysis, nevertheless had emphasized the importance of its dynamic concepts. G. Stanley Hall in psychology, Ernest Jones and Brill in psychiatry, and J. J. Putnam in neurology were among the staunchest and most influential early proponents of psychoanalysis. They were very soon joined by Jelliffe and White who, through the medium of the *Nervous and Mental Disease Monographs* and, particularly, the *Psychoanalytic Review* (founded in 1913) began to offer original contributions both in regard to the theory and the therapeutic principles of this new method. In 1911 the New York Psychoanalytic Society was formed, to be followed a few months later by the foundation of the American Psychoanalytic Association.⁸³ Psychoanalysis had gained a solid footing as a method of treatment in psychiatry.

The Association was rather slow in inaugurating official discussion on psychoanalysis. The first paper was presented by Burr in 1914,⁸⁴ the author taking a definitely critical attitude. It must be added here that when, in 1916, White⁸⁵ presented the next paper on the subject, introducing it in a sane and cautious manner but in decidedly favorable terms, Burr was the only one to speak in favor of White's contribution. In spite of the efforts of men like White within the ranks of institutional psychiatry, psychoanalytic methods in the treatment of personality disturbances were slow in gaining a foothold in institutions. We must remember, however, that it was not until later in the history of the movement that attempts were made to use psychoanalytic procedures in the treatment of psychoses. Since its primary application was in the neuroses, it found its first practical use in this country in extramural practice. Here a mutually supplementary relationship was established. It was the man working on the outside who found a practical field for the application of this new method, and it was psychoanalysis that to a large extent, either directly or in-

⁸² See Freud, "The Origin and Development of Psychoanalysis," *Am J Psychol*, XXI (1910), 181.

⁸³ C. P. Oberndorf, "History of the Psychoanalytic Movement in America," *Psychoanalytic Rev.*, XIV (1927), 281.

⁸⁴ C. W. Burr, "A Criticism of Psychoanalysis," *Am Medico-Psychol. Assn., Proceedings*, XXI (1914), 303.

⁸⁵ William A. White, "Psychoanalytic Tendencies," *ibid*, XXIII (1916), 275.

directly, gave these men a practical method for the treatment of most of their patients.

Even if the theory and the method of psychoanalysis were not generally accepted in those early days, nevertheless its principles were gradually absorbed and began to have an effect on general psychotherapeutic work in the field. At about this time, psychopathic hospitals began to be constructed in connection with universities, it was in these that the importance of dynamic factors in the development of mental disease and the necessity of dealing with them in attempts at treatment began to be recognized. Whether or not psychoanalysis was directly given the credit, its influence gradually permeated into the ranks of official psychiatry. The psychopathic hospitals were, to a large extent, the training centers for the young men in the profession, and as these went out into their respective localities they carried the new point of view with them.

Another important factor influencing the progress of psychiatric treatment at this time was the mental hygiene movement. Strictly speaking, when we consider the specifically preventive aspect of this work, it cannot be classified as a method of treatment, and the history of its development and progress will be found in another chapter in this volume.⁶⁶ However, there are two aspects of the mental hygiene movement that directly concern us here. In the first place, there is a close relationship between mental hygiene and treatment in that they acted in a mutually supplementary fashion. The discovery of the importance of dynamic factors in the causation of mental disease, made in the process of searching for psychotherapeutic implements, made it possible for mental hygiene to be developed on a scientifically valid basis. The contributions of Meyer and White and the psychoanalytic theory provided the foundations for the present-day mental hygiene movement. At the same time, the study of incipient personality disturbances and problems of childhood, which were a natural field of activity for mental hygiene, has contributed a great deal to methods of treatment particularly in problems of childhood and adolescence. In the second place, although theoretically the primary concern of a mental hygiene movement should be preventive psychiatry, practically it was inevitable that a large proportion of the activities of both the national and local mental hygiene societies should consist of surveys of the care and treatment of the insane and mental defectives. Among the most important of the movement's contributions

⁶⁶ See Albert Deutsch's chapter on "The History of Mental Hygiene."

were the great improvements in hospitals that these surveys indirectly brought about.

From a historical point of view it is important to bear in mind that mental hygiene is not altogether a new field. The present mental hygiene program could develop only after the establishment of a systematic appreciation of clear-cut clinical pictures, as was offered by the Krapelinian school and the subsequent investigations that brought appreciation of the importance of social and psychological stress in early life as contributing to or causative of personality disturbances. The fascinating story of Clifford Beers' work in this field on the basis of his own experiences and struggles is one for which we must refer the reader to the appropriate chapter.⁸⁷

In close connection with the subject of mental hygiene stands the beginning of another trend that started about the same period—the development of interest in juvenile delinquency. The whole subject of criminology and jurisprudence had for obvious reasons interested the psychiatric profession for a long time. From the earliest days of the Association the importance of psychiatric opinion in regard to responsibility for and the motivation of crime had been recognized by the legal profession, and we find a fairly steady flow of contributions on the subject by psychiatrists both here and abroad. In this country, the name of Isaac Ray is the first that comes to mind in this connection.⁸⁸ Comparatively little, however, was done on the question of motivation, and still less in any attempts at treatment. Again, it was only after the whole question of dynamic motivations in human behavior began to come to the fore that criminal behavior became accessible to understanding and treatment along the same general lines as mental diseases.

Obviously, the most promising point of attack on this problem, both from the standpoint of understanding and treatment, was the juvenile criminal.⁸⁹ Outstanding in the ranks of workers in this field was William Healy who, in 1909, founded the Juvenile Psychopathic Institute at Chicago in connection with the Juvenile Court. For years he continued his investigative, advisory, and therapeutic work and, in time, the justification of his concepts and the practical value of his work were amply proved by the numerous clinics that were established throughout the

⁸⁷ See pp. 356–364.

⁸⁸ Isaac Ray, *Medical Jurisprudence of Insanity* (Boston, Little, Brown, 1838); see also Dr. Zilboorg's chapter on "Legal Aspects of Psychiatry."

⁸⁹ See Albert Deutsch's chapter on "The History of Mental Hygiene."

country in connection with juvenile courts. It is difficult to make a really adequate estimate of his work since, to a large extent, it deals with young delinquents on the basis of their immediate problems in order to prevent more serious future breakdowns, it is impossible, of course, to determine in retrospect how many of these would have broken down had they not been treated.

As time went on, both of these fields of activity—mental hygiene and research in juvenile delinquency—contributed to the development of a new field, that of child guidance, which bids fair to achieve equal proportions if not actually to supersede its parent organizations.

It is natural to expect that those methods of treatment which had gained a solid footing in the confidence of psychiatrists and had become firmly established tended to be taken as a matter of course, and since they gave rise to little controversy scant attention was paid to them at the Association meetings or in the literature. Practically all the hospitals were by this time firmly convinced of the efficacy of such traditional methods as proper occupational therapy, hydrotherapy, adequate diet, and appropriate surgical and medical treatment for conditions that required them. Endocrine therapy had carried over into this period, with particular attention being paid the thyroid. Such sporadic fads as the radical extirpation of the thyroid gland in catatonias, and so forth, came and went without much appreciable effect. At about this time deficiency diseases first began to attract attention, especially pellagra. This interest, however, was still in the embryonic stage; papers were occasionally presented at the meetings discussing such problems as, for instance, whether the relationship of pellagra to a corn diet might not in reality be due to some toxic agent contained in the corn.⁷⁰ Mention should also be made of a new subject that began to attract the attention of psychiatry in these years—the matter of focal infection. There was much heated discussion and controversy in the field of surgery introduced particularly by Sir Arbuthnot Lane in England, on the importance of foci of infection and auto-intoxication, particularly that originating in the gastro-intestinal tract. There was a wave of indiscriminate removal of various organs considered as the culprits in causing the most variegated types of diseases, and mental diseases of course could not escape being included. Henry A. Cotton must still be vividly remembered by a good many psychiatrists

⁷⁰ C. C. Bass, "Treatment of Pellagra," *Am Medico-Psychol. Assn, Proceedings*, XVIII (1911), 315.

today as the principal champion of this cult in psychiatry. During the period under present consideration, however, he made only one indirect reference to this subject.⁷¹ It was only in 1918 that Cotton first began to work on it, and his contributions on the subject appear mainly during the first few years after World War I.

The psychiatric experiences of World War I have had a profound influence upon our understanding of the nature and causes of personality disturbances and gave rise to new points of view in their treatment. It was a war which surpassed most such cataclysms, both in its vast proportions and in its unprecedented forms of stress and strain. The psychiatrists and psychologists who were drawn into it had the opportunity to observe, in something of an experimental laboratory, the development of personality disturbances of a type and uniformity that made them particularly accessible to scientific investigation. Therapeutic measures could be applied en masse, causative factors could be studied in the making, and mechanisms were particularly vivid and sometimes naively superficial. A good many of the psychiatrists who worked with such conditions had also had the advantage of a great deal of experience in pre-induction examinations. As a result, soon after the armistice and demobilization there was a marked rise in contributions dealing with various types of investigations in this field.

Perhaps the most important of these, certainly from a numerical point of view, were the contributions in mental hygiene. Thomas W. Salmon and Frankwood E. Williams, both of whom had had long experience in war psychiatry, brought their energies and accumulated knowledge to bear upon this problem, which they rightly considered one of the most important of the day.⁷² As we follow Chart II, in which an analysis of the papers on treatment is presented, we can see that those on mental hygiene (including child guidance) occupy the first place. Those interested in this problem had first been concerned with attempts at reform in the care and treatment of mentally sick people. Now they also began to deal directly with prevention, through study of the psychological and social stresses that tended either to cause or to precipitate such illnesses. Slowly, and especially under the influence of Frankwood E. Williams, psychoanalytic principles were introduced into this work, although not of course without a good deal of controversy.

⁷¹ H. A. Cotton and F. S. Hammond, "Cardio-Genetic Psychoses," *ibid.*, XVII (1910), 357.

⁷² "Symposium on Mental Hygiene" (Abbot, Kline, Truit, *et al.*), *ibid.*, XXVII (1920), 151-209.

Closely related to the progress made in mental hygiene were the new developments in the various fields of psychotherapy. Psychoanalysis was beginning to get into its stride, and although it still had not reached its peak as far as its representation at the meetings of the Association is concerned—it was not to reach this until late in the twenties—psychoanalysis was widely discussed and no longer so vehemently opposed as in earlier years. Its widest application at that time was still in private practice, especially in the treatment of the neuroses. It is interesting to note in passing that to a certain extent this step-child of legitimate psychiatry has provided the latter with an opportunity of sharing some of its newly gained knowledge with neurology; incidentally, it has even served as a somewhat belated repartee to Weir Mitchell's address of 1894. It is true, of course, that psychoanalysis may be regarded as coming from the field of neurology, since Freud was primarily a neurologist when he first developed his method. In this country, however, except for the very early days psychoanalysis was sponsored, preached, and practiced mainly by psychiatrists. Whatever the feelings among the older group of neurologists, the younger generation soon began to follow the psychiatrists in the utilization of psychoanalytic principles. This was to be expected since, with the large proportion of psychoneuroses in the private practice of neurologists, this method of treatment would be of the greatest practical use. Psychoanalysis also proved to be one of the important links between psychiatry and general medicine. It is significant that at the 78th annual meeting of the American Medical Association the section on the practice of medicine held a symposium on the importance of psychic factors in cardiac, gastrointestinal, and other somatic diseases.⁷⁸ The principles stressed by psychoanalysis were reflected in the experiences of representatives of general medicine; we may regard this meeting as one of the starting points of the modern development of psychosomatic medicine.

As far as the general psychiatric profession of this time is concerned, however, its interests were in the field of what might be called "eclectic" psychotherapy. This had gradually grown up on the basis of the teachings of such men as Meyer, White, and their followers, liberally supplemented by principles of Freudian psychoanalysis or modifications of it, and by the methods of Adler, Jung, and others. A number of methods evolved, differing in some aspects but based on the same broad foundation of

⁷⁸ "Symposium on Psychic and Emotional Factors in Disease," *J A M A*, LXXXIX (1927), 1013.

treating personality disturbances through the medium of an analysis of the patient's life problems, his historical background, his social and psychological needs, supplemented by readjustment of his environmental settings and a practical system of re-education. It is important to note that, as we follow developments through the last twenty-five years, this type of psychotherapy can be seen to have gained favor. Instead of gradually dwindling to a narrower scope or steadfastly adhering to old traditions, such psychotherapy became the background of a great many of the methods of treatment that were subsequently developed. Newly introduced drugs, for instance, found one of their most useful applications as adjuncts in psychotherapy; the more recently developed shock therapies were found, among other things, to facilitate psychotherapeutic contacts, and so on.⁷⁴

Toward the end of World War I and for a few years after it, a great deal of interest was aroused by discussions on the role played by focal infections in the causation of mental diseases. In 1919⁷⁵ the first report was made at a meeting of the Association on the treatment of mental diseases by surgical removal of such foci of infection. There followed a long series of papers both by proponents of this method, the most enthusiastic of whom was Cotton, and by its critics such as Kirby, Kopeloff and their associates. The latter undertook a series of most careful and scientifically controlled investigations on the subject,⁷⁶ and through their efforts and those of others who followed them the true worth of this method was established. The wholesale removal of various parts of the gastrointestinal tract, teeth, tonsils, and prostate—a practice which, aside from its irrelevance in most cases, was actually dangerous in a good many—was finally given up and surgery once more receded to its logical function of treating surgical conditions only.

Distinct progress in the treatment of general paresis was brought about in this period through the introduction of fever therapy. It originated in Vienna where Wagner-Jauregg began to treat paresis by inducing a fever through inoculation by the malaria plasmodium; he had been

⁷⁴ The literature on the various methods of psychotherapy is, of course, very large. A good exposition of the subject and an adequate bibliography is found in Paul Schilder's *Psychotherapy* (New York, W. W. Norton, 1938).

⁷⁵ H. A. Cotton, "The Etiology and Treatment of the So-called Functional Psychoses," *Am J Psychiatry*, LXXIX (1922), 157.

⁷⁶ N. Kopeloff and G. H. Kirby, "Focal Infection and Mental Disease," *ibid.*, LXXX (1923), 149.

working along these lines for a number of years in relation to this and other mental diseases. The first results of the treatment were so successful that a number of other clinics in Europe, notably Hamburg and Munich, investigated and reported very promising results. White introduced it into this country at St. Elizabeths in 1922,⁷⁷ and soon the New York Psychiatric Institute, the Boston Psychopathic Hospital, and a large number of other clinics and state hospitals followed suit. There is no doubt but that this was the first really successful treatment of general paresis; henceforth and up to the present time this form of fever therapy or others which were introduced as useful alternatives have become the accepted method of treatment. Careful workers have come to the conclusion that the most successful method of dealing with general paresis is a combination of fever therapy with one or another form of arsenical preparations, particularly tryparsamide, as was demonstrated by Solomon.⁷⁸ The promising results produced by this method led, as could be expected, to attempts to use fever therapy in other mental diseases and some of the organic, degenerative diseases of the nervous system. Schizophrenia, manic-depressive psychoses, multiple sclerosis, and others were repeatedly subjected to this treatment, but without sufficiently good results to warrant universal acceptance.

To the postwar period, too, belongs a significant development in the use of drugs in psychiatry. Until the end of the second decade of this century sedatives and hypnotics were used primarily for symptomatic treatment—to relieve pain and suffering, to reduce restlessness and agitation, and to produce sleep. In 1922 Klaesi⁷⁹ reported good results in the treatment of schizophrenia by continued narcosis by the administration of somnifen. A number of workers both in Europe and in this country had tried this method with varying degrees of success—sometimes, however, with reports of injurious sequelæ mainly because of decreased resistance and the development of intercurrent infections. Whether because of this danger or for some other reasons, its use has never gained any high degree of popularity. In 1930 Bleckwenn of Wisconsin published the results of ten years' experience with the use of barbiturates, particu-

⁷⁷ N. D. C. Lewis, L. D. Hubbard, E. G. Dyar, "The Malarial Treatment of Paretic Neurosyphilis," *ibid.*, LXXXI (1924), 175.

⁷⁸ H. C. Solomon and S. H. Epstein, "Tryparsamide in the Treatment of Neurosyphilis," *N. Y. State J. Med.*, XXXI (1931), 1012.

⁷⁹ J. Klaesi, "Ueber die therapeutische Anwendung der Dauernarkose," *Zeitschr. f. d. ges. Neurol. und Psychiatrie*, LXXIV (1922), 557.

larly amytal, in the treatment of mental diseases,⁸⁰ and stressed their effects in altering the emotional state of the patient by increasing his contact with the outside world. This led to the idea that such drugs would be of value as auxiliary agents in the psychotherapy of those mental diseases where the necessary emotional rapport with the patient was not otherwise procurable—an idea which was followed up by others with very good results. Schizophrenic withdrawal, depressive retardation, and other conditions which make patients inaccessible to psychotherapy were found to be favorably influenced by intravenous injections of sodium amytal. Under its effects the patient became more communicative, developed better rapport, and even a certain degree of euphoria. This method is now being used successfully by a number of psychiatrists, and it has materially enhanced the applicability of psychotherapy.

Mention has been made of the growth of the child guidance field. It should be reemphasized that the successful work of the Chicago Institute had a direct bearing on the development of the child guidance clinics. In 1913 the Henry Phipps Psychiatric Institute and the Boston Psychopathic Hospital opened children's clinics, and since then a number of others have followed their example. A specifically designated child guidance clinic was first opened in 1922 under the auspices of the Mental Hygiene Committee and the Commonwealth Fund, largely through the influence of Thomas W. Salmon. As George S. Stevenson⁸¹ describes it, it was designed to be a "psychiatric clinic for the diagnosis and treatment of behavior and personality problems of childhood." It was neither to attempt to treat the particular symptom shown nor even the child himself, but instead there was to be a joint attack by psychiatrists, psychologists, and social workers on all the factors that could be considered as operative in the development of the particular problem.

Closely related to this work was the establishment of habit clinics for the study and treatment of behavior problems of infancy and early childhood. The first clinic of this type was established in Boston in 1921, under the direction of Douglas A. Thom. The purpose of both habit and child guidance clinics is two-fold. On the one hand they provide suitable treatment for behavior problems, in the same sense that mental diseases in adults are treated in mental hospitals. On the other hand, they afford

⁸⁰ W. J. Bleckwenn, "Production of Sleep and Rest in Psychotic Patients," *Arch. Neurol. and Psychiatry*, XXIV (1930), 365

⁸¹ G. S. Stevenson, quoted by Deutsch, *op. cit.*

opportunity for an attempt at prevention of more serious abnormal reactions as the natural exaggeration of these earlier problems. Since its inception, the child guidance movement has grown remarkably, and numerous clinics are now available for this work throughout the country.

Throughout the postwar years, as in previous periods, there were further developments in some of the more general supportive and symptomatic methods of treatment. Occupational therapy received a great deal of attention, several contributions designed to introduce new ideas in the application of these procedures were presented at the meetings, and variations applicable to the special types of mental diseases were devised and applied with progressively better results. Hydrotherapy was similarly brought to a higher degree of efficiency. Kellogg,⁸² Rebecca Wright,⁸³ and others investigated the physiological effects of various hydrotherapeutic procedures upon different types of mental syndromes, basing both the mechanical and hydriatic techniques of their application on scientific principles. The improvements in these two procedures resulted not only in an increased efficacy of the general treatment of mental diseases but also in a definite decrease in the need for mechanical or chemical restraint. The old principles preached by the early founders of the Association and more recently by men like White—that the best road to nonrestraint was to discover methods that would make restraint unnecessary—were now realized through the rational application of occupational therapy, hydrotherapy, and psychotherapy.

By this time, too, state hospitals began to emerge from their isolation by the establishment of out-patient clinics and other coöperative contacts with general hospitals. This emergence first began to be noticeable even before the War, and papers on the subject were presented at Association meetings as far back as 1915. Early in their development the psychopathic hospitals realized the importance of offering the community possibilities for early treatment of patients who had not as yet reached a stage where institutionalization was necessary. Various state hospitals soon followed suit and established clinics manned by members of their staffs, either in their own hospitals or as parts of general hospitals in the community. Because of the particular need for such treatment in the case of war casualties after demobilization, a large number of these clinics

⁸² J. H. Kellogg, *op cit.*

⁸³ Rebecca Wright, *Hydrotherapy in Hospitals for Mental Diseases* (Boston, Tudor Press, 1932)

were established throughout the country. They served the double function of giving badly needed help in cases of war casualties and of serving as an excellent means of broadening the outlook of state hospital psychiatrists and of combating the isolationism which was inevitable when these physicians dealt with nothing but definitely psychotic patients.

As was pointed out earlier in this chapter with reference to the founding of the Pennsylvania Hospital, the practice of establishing facilities for in-patient care of psychiatric cases in general hospitals is very old, but later developments had tended away from this procedure. With progress in psychiatry and the gradual confidence that psychiatrists developed in the importance and efficacy of their work, and with the growing awareness of the need for early treatment of mental diseases, there was a gradual return to that practice. The first manifestation of this return to a former practice was the foundation of the psychiatric ward in the Albany General Hospital in 1902. Owing to the slow permeation of this idea into the ranks of psychiatry, and because of the lag on the part of other branches of medicine either in appreciating the need or recognizing the feasibility of such a plan, it is only recently that a larger number of such wards developed. It has been pointed out that the psychoanalytic movement was an important factor in establishing a link between psychiatry and general medicine. The gradual recognition of the importance of emotional factors in the development of some apparently purely somatic manifestations helped in bridging the still-existing gap. A new development appeared, in the form of psychosomatic medicine, which has done a great deal to introduce psychiatry into the wards of general hospitals; at present a great many such liaison centers exist throughout the country.

As one views the chart representing the gradually increasing number of contributions presented at the annual meetings of the Association, one notices the impressive rise toward the end of the third and the beginning of the fourth decade of this century in the number of papers in general, and more specifically the rise in those dealing with treatment. This increase was not only limited to the programs of the Association but was also reflected in the publications in the then existing journals, the development of new journals, the appearance of an increasing number of monographs and books, and the generally larger amount of work done in hospitals. There is no one particular event that seems to account for these facts, and one might speculate as to the underlying reasons. Was it

a reflection of the first rumblings of that social upheaval that has finally begun to express itself in the present war? Have the manifestations of this unrest resulted in increased disturbances, creating more opportunities for observation and greater needs for treatment of personality disturbances? Was it partly due to the influx of a considerable number of eminent psychiatrists into this country, as they were gradually forced to leave their homelands? Certainly men like Schilder, Goldstein, and many others have tended to swell the ranks of able investigators in America. The fact is that such a sharp rise in psychiatric activity has occurred, and it has resulted not only in more contributions but in greater interest in investigative work by members of the Association and representatives of allied fields.

The first marked rise along any one line is to be noted in psychotherapeutic and, specifically, psychoanalytic work. A new development is found in the attempts to apply both types of treatment not only to the psychoneuroses but also to the psychoses. It is true that the first ventures on the part of psychoanalysis in this direction date back to Freud and Abraham some years before, but these attempts were largely theoretical and sporadic in nature. The main emphasis of psychoanalytic efforts had been concentrated for a long time on the treatment of the psychoneuroses. In the thirties, however, both orthodox methods and their modifications were beginning to be applied to the treatment of schizophrenia, manic-depressive psychoses, paranoid states, and others. There was also an increase in attempts to apply systematically formulated eclectic psychotherapy to these conditions. One reason for the increase in contributions along these lines was the realization of the importance of combining rational psychotherapy with whatever other modes were being introduced. Whether these were drugs, or occupational therapy, or finally the more recently introduced shock methods, psychiatrists began to realize that multi-dimensional attacks with the predominance of personality analyses offered the greatest opportunity for effective therapy.⁸⁴

A highly promising development among the new angles of approach was opened up by the introduction of more systematic endocrine therapy in the treatment of mental diseases. In this respect, the combined work of gynecologists and psychiatrists in the treatment of menopausal syn-

⁸⁴ The literature on the subject is extensive. A good reference book on this and other contemporary therapies in psychiatry is O. Diethelm's *Treatment in Psychiatry* (New York, Macmillan, 1936).

dromes was of importance. Of still greater value, however, was the growing recognition of the important interrelation between the endocrine system and the emotional life of the individual. Cannon's work⁸⁵ provided great stimulation along these lines. The most important systematic attempt in this direction is the critical work of R. G. Hoskins and his associates at the Worcester State Hospital.⁸⁶ The gradual progress that has been made in recent years in biochemical and metabolic procedures was particularly helpful in establishing this field on a sound scientific basis; the new knowledge contributed to an understanding of both the nature of these diseases and their treatment.

Within the past few years, further progress has also been made in the borderland between psychiatry and the other medical sciences, and psychosomatics has become firmly established both in mental and general hospitals. Special clinics have been set up in general hospitals for the study and treatment of such problems as psychoneuroses, or even mild psychoses, but particularly for the treatment of the so-called "organ neuroses." The appreciation of the importance of psychic factors in the development of organic disease has come a long way in the last few years, and now a large corps of workers trained both in general medicine and in psychiatry are concentrating on the treatment of such conditions as hypertension, skin diseases, gastrointestinal disturbances, allergies, and so forth. The subject has gained the interest of so many workers that recently a society was founded (1942) which is primarily concerned with research in psychosomatic medicine; a journal devoted to this subject was established in 1939.⁸⁷

Closely related to this field is the work that has been done in the treatment of drug addiction, particularly of alcoholism in its chronic and acute stages. On the one hand, much has been accomplished in the study of personality factors and social and psychological stress situations that lead to the development of these addictions and contribute to the precipitation of pathological mental reactions. Psychotherapeutic and social treatment have done a great deal to help in the readjustment of such people. On the other hand, a great deal more has been learned of the

⁸⁵ W. B. Cannon, *Bodily Changes in Pain, Hunger, Fear, and Rage* (New York, Appleton, 1915).

⁸⁶ R. G. Hoskins and F. H. Sleeper, "Endocrine Studies in Dementia Praecox," *Endocrinology*, XIII (1929), 245.

⁸⁷ Good references on this subject will be found in H. F. Dunbar's *Emotions and Bodily Changes* (2d ed., New York, Columbia Univ. Press, 1938), and in E. Weiss and O. S. English's *Psychosomatic Medicine* (Philadelphia, Saunders, 1943).

organic etiology of the psychoses, and of those caused by alcohol particularly. One of the most important recent contributions has been the discovery of the importance of nutritional factors in the causation of such conditions as delirium tremens, the Wernicke syndrome, and Korsakoff psychosis.⁸⁸ Dietary procedures, particularly the use of vitamins, and the administration of glucose and insulin have produced highly promising results. Here again, so much interest was aroused by these results, as well as by the recognition of the devastating effects of the abuse of alcohol, that a special society was formed for investigation of the effects of alcohol on behavior, and the *Quarterly Journal of Studies on Alcohol* was founded in 1940.

Another important development has been the introduction of a new form of fever therapy in general paresis. Ever since the introduction of malarial therapy its disadvantages have been apparent to many, and since it was felt that fever was the active factor of the treatment, efforts were made to find a preferable substitute. In 1929 Neymann and Osborne first described the production of electropyrexia⁸⁹ and later reported successful results in cases of general paresis. Shortly thereafter this form of treatment was taken up by others, and at present electropyrexia or modifications of it are being used extensively, although it has not altogether replaced the use of malaria. Both types of fever therapy are used in combination with chemotherapy, and although some difference of opinion exists as to the relative merits of each, it is commonly agreed that either one used in combination with arsenicals is far superior to the old chemotherapeutic method alone.

The therapeutic methods most recently introduced into psychiatry, and the ones that are now most widely discussed both by psychiatrists and the lay public, are the so-called "shock" therapies. As is the case in any other newly introduced method, one can trace a relationship to certain procedures that were used before and that could be regarded as more or less closely associated precursors. The use of ether and chloroform in the early years of the Association, and the use of high concentration of CO₂ more recently, come to mind as related practices, not to mention the still earlier treatment of sudden immersion in cold water, or the utiliza-

⁸⁸ "Symposium on Alcoholism of the Research Council on Problems of Alcohol," *Q J Studies on Alcohol*, I (1941), 794, the papers presented were published in subsequent numbers of the *Journal*

⁸⁹ C. A. Neymann and S. L. Osborne, "Artificial Fever Produced by High Frequency Currents," *Ill Med J.*, LVI (1929), 199

tion of frightening experiences. None of these methods, however, would seem to have exerted as far-reaching an influence on psychiatric practice, or to have produced as promising results, as some of the present-day shock methods. The term "shock" therapy has come to be popularly applied to three forms of procedure: insulin hypoglycemia and metrazol- and electric convulsive therapies.

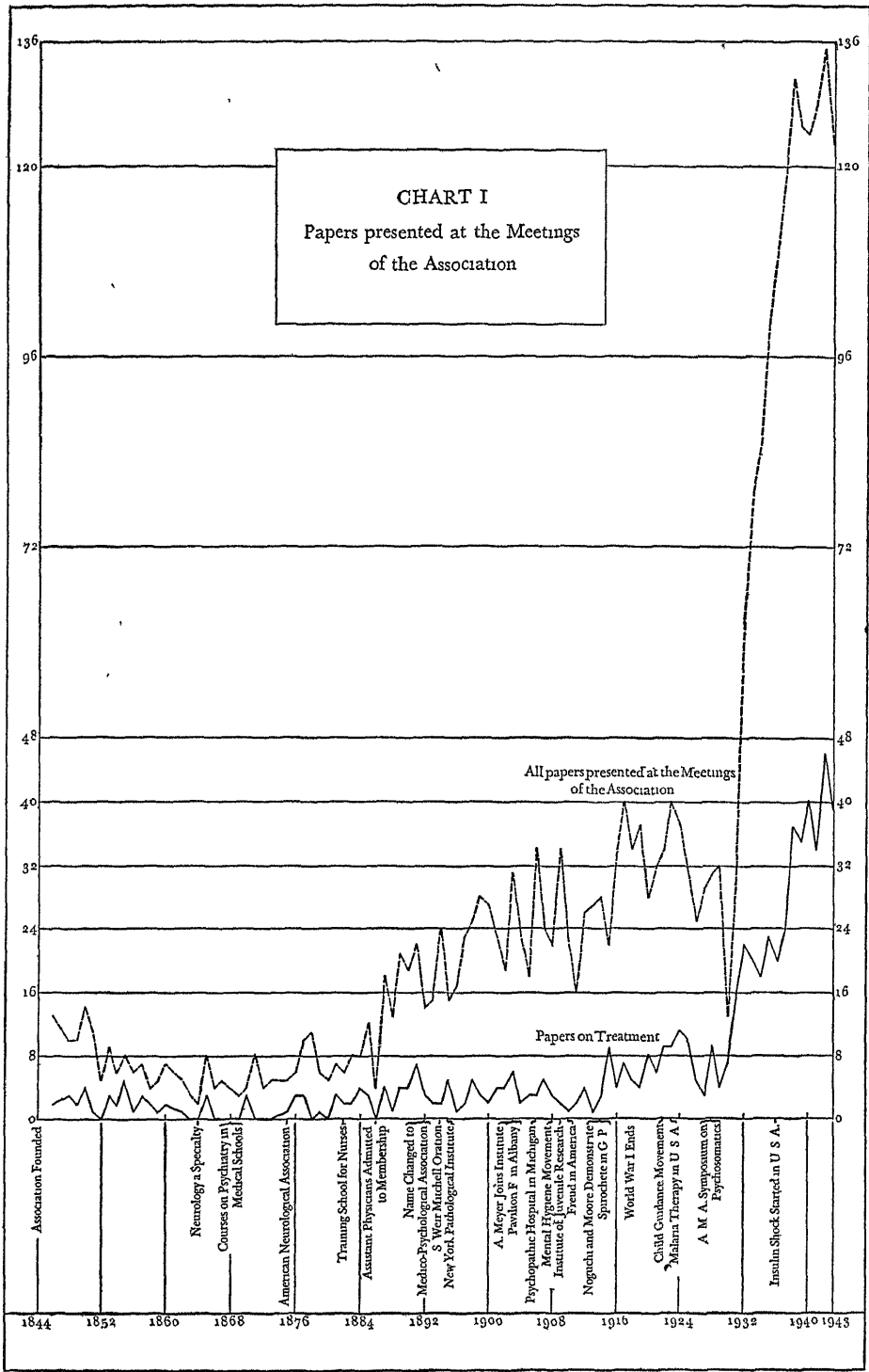
The first of these to be introduced was insulin therapy. The effect of hypoglycemia on certain types of mental disturbances was first noted by Sakel of Vienna while using insulin in the treatment of drug addiction. Later he applied it in the treatment of schizophrenia; after a few preliminary investigations by such men as Muller in Europe, insulin therapy was introduced in this country. It was first used here by Cameron and Hoskins in the Worcester State Hospital in 1936,⁸⁰ and since that time it has enjoyed a remarkably wide acceptance throughout the country. The use of insulin as well as of the other shock methods is so universal and so much in the foreground now that an appraisal of it here is neither necessary nor possible.⁸¹ At first, as might have been expected, its results were vastly overrated and reports of recoveries—reminiscent of the "cult of curability"—ran as high as 90 per cent. Furthermore, there was a tendency in some cases to regard insulin as a universal panacea for all kinds of diseases. It is a mark of the progress of modern times that, during the very short period of its existence, it has already settled down to a more sober application; its value is now recognized as being definitely limited.

The next of the shock methods, chronologically, was the metrazol convulsive shock therapy. This was first described by von Meduna in 1933 and was subsequently imported to this country. It came over in the wake of insulin therapy and at first was overshadowed by its predecessor. It has since, however, found a great many supporters; following a brief period marked by unwarranted enthusiasm, it too has settled down to use in certain types of mental diseases, particularly those marked by depression, agitation, and excitement.

Finally, the third method, the most recent of the three—the electric convulsive shock treatment—bids fair to outstrip both of the others from the point of view of its usefulness and comparative ease of application.

⁸⁰ D. E. Cameron and R. G. Hoskins, "Experiences in the Insulin Hypoglycemia Treatment of Schizophrenia," *J. A. M. A.*, CIX (1937), 1246

⁸¹ L. Jessner and V. G. Ryan, *Shock Treatment in Psychiatry* (New York, Grune and Stratton, 1941).



In its present form it was first used in the treatment of mental diseases by Cerletti and Bini, who published their results in 1938 in Italy.²² Its obvious advantages over both of the other two forms of shock treatment, especially in regard to the method of administration, were soon recognized in this country; knowledge of it spread quickly, and it is now being used in a great many hospitals. Owing to the comparative ease of its administration and the lesser dangers it involves, it has recently been introduced even into private practice.

During the course of time many modifications have been introduced into the methods of application of all three of these forms of shock treatment, principally to increase the efficiency of administration and to eliminate some of the complications such as fractures, delayed reactions, and so forth. The contraindications in terms of physical diseases that make this type of treatment dangerous have been determined, thus removing possibilities of untoward sequelae. In time, also, more knowledge has been acquired in regard to the particular diseases in which these methods are especially useful. Insulin shock therapy has been fairly well limited to certain types of schizophrenia; the convulsive methods in general have been found to be most useful in the agitated depressions, states of excitement either manic or schizophrenic, and to a lesser extent in the retarded or apathetic states.

The shock therapies may be said to have had twofold results: In the first place, their use has produced successful results in the treatment of mental diseases. It is difficult at this time to determine what degree of permanency these results may have. In some cases they are obviously of a temporary nature. In others, such as for instance is the case with the electric shock in agitated depressions, they seem to be of more lasting effect. But even if the latter were not the case, the shock therapies have certainly been of great help in controlling some of the behavior disturbances, at least temporarily. They have lessened the dangers of exhaustion in the cases of excitement and agitation, as they have lessened the lack of regard for environment in the more retarded or apathetic states. Recently it has also been observed that in some patients who were inaccessible to psychotherapeutic attempts the shock therapies have reduced the inaccessibility; in many cases a combination of the two methods—shock and psychotherapy—is now being used with good success.

In the second place, the stimulation afforded by the sensational re-

²² Quoted from Jessner and Ryan, *op. cit.*

sults, in conditions where everything else had failed, has served to encourage research extending beyond the limits of therapy. The search for physiological or psychological reasons for these curious therapeutic phenomena has attracted a host of investigators from both within the ranks of psychiatry and outside of them. So far no adequate explanation has been found for the results of shock therapy, but in the process of searching for it a large number of valuable contributions have already been made.

At the present time psychiatry has entered a new field of activity which, aside from more general considerations, is of vast importance in its significance to the profession and in its implications with reference to future developments. Throughout this country and abroad psychiatrists either are engaged in active work in the military services or are carrying on various special tasks created by the present situation in addition to their normal activities. The unprecedented nature of the present warfare, both in regard to actual combat conditions and to the effects upon civilian populations, has produced new and special problems for which our traditional techniques and methods have been found to be inadequate. In that respect, even the knowledge that was gained in the last war proved insufficient in dealing with the new needs introduced by "total" war.

It is not the function of the historian to make a survey of problems that are still within the process of development, much less to attempt either suggestions or predictions as to their solution. Furthermore, the experience that has already been gained in Europe and in this country during the first four years of the present war have not as yet become consolidated to a point where they can be adequately appraised as to their validity or the results they have produced. Certain features, however, do stand out even now and may be considered, at least to a certain extent, as accomplished contributions. A great deal has been learned from the work of screening out psychiatric risks from the armed services. Criteria of selection have been established and systems for their practical application have been devised, some of which have already reached a point where they are being systematically utilized. In the European countries where the imminence of war as well as its actual existence has conditioned a great deal of the thinking and investigative work for a longer period of time, many contributions have been made to an understanding of the mechanisms of the development of personality disturbances both in members of the armed forces and in civilians, in reference

to this severe stress situation. It is understood, of course, that in a situation where prompt action is important no elaborate plans for treatment can be considered or carried out. At the same time, there are indications of attempts to organize such plans for the future, and an effort is being made to apply them practically wherever the opportunity presents itself. Such work is already being done in some of the hospitals in this country.

Another matter which is definitely a problem for the future, but for which plans can be and are even now being organized in some quarters, is that of rehabilitation. Some members of the armed forces are already returning to their communities either from training camps or from actual combat areas, and the experience gained from efforts to readjust these men will be of great value at the end of the war. The experiences of previous wars have taught us how much we can learn from such situations, not only in reference to war casualties but also in relation to psychiatric problems in general. It is not too rash to predict that the present war, too, will have a profound effect upon the future developments in our profession.



NEHEMIAH CUTTER

ALBERT DEUTSCH

THE HISTORY OF MENTAL HYGIENE

THE term "mental hygiene" has undergone some curious mutations since its introduction into this country about a century ago.

So far as I can discover it first appeared in 1843 as the title of a book by Dr. William Sweetser (1797-1875), professor of the theory and practice of physic at the University of Vermont. Dr. Sweetser was a prolific author of medical writings for professional and popular consumption, and a number of his shorter works earned awards in medical essay contests.

His book *Mental Hygiene* may be considered a pioneer work in the United States on what is now known as psychosomatic medicine. The thesis of his book was stated pithily in the subtitle—*An Examination of the Intellect and Passions, Designed to Illustrate Their Influence on Health and the Duration of Life*. A somewhat broader description of Sweetser's object was given in the preface: •

The leading design of the present volume, as its title implies, is to elucidate the influence of intellect and passion upon the health and endurance of the human organism. This influence, we believe, has been imperfectly understood and appreciated in its character and importance by mankind at large. Few, we believe, have formed any adequate estimate of the sum of bodily ills which have their source in the mind. Those of the medical profession, even, concentrating their attention upon the physical, are too prone to neglect the mental causes of disease; and thus may patients be subjected to the harshest medicines of the pharmacopæia, the true origin of whose malady is some inward and rooted sorrow, which a moral balm alone can reach.¹

The "passions" of those days were the equivalent of our present-day "emotions," except that they were then much more heavily tinged with moral attributes. Sweetser, like many of his contemporaries, differentiated between the "pleasant passions"—such as love, hope, and friendship—and the "unpleasant passions"—fear, anger, grief, and shame. Jealousy and avarice were treated separately as "mixed passions."

Sweetser's book may be briefly summarized as follows:

The "pleasant passions" are conducive to mental and physical well-being, and so should be cultivated. The "unpleasant" ones, when mani-

¹ William Sweetser, *Mental Hygiene* (New York, J. and H. G. Langley, 1843), p. x.

fested strongly and at length, tend to create or to stimulate bodily as well as mental ills. Mental inactivity has a deteriorating influence on the body, intellectual overexertion is likewise injurious to physical health. In brief, Sweetser urged moderation in all things as the *summum bonum* of mental hygiene. This simple advice to follow the *via media* toward the goal of mental health was to remain the kernel of the concept of mental hygiene throughout the nineteenth century, as it had, indeed, been advocated for centuries before.

One noteworthy feature was Sweetser's insistence on the essential unity of body and mind, of intellectual and emotional activity. He continually stressed the point that distinctions between these terms were merely verbal conveniences used in discussing the human being, who operated as a unit.

In this, Sweetser differed materially from the dualistic approach advanced in Baron Ernst von Feuchtersleben's classic work on a similar theme, *Zur Diätetik der Seele* (translated into English as *The Hygiene of the Soul*), which had appeared in 1838. Feuchtersleben, an outstanding writer on psychological matters, also set out to show that bodily health, for good and ill, was influenced by the mind and the "passions." But his book reflected the strong strain of philosophic dualism then running through German psychiatry. He made a distinct separation between the physical and spiritual attributes of man; his main point was that physical and mental ill health could be avoided by the exercise of will power.

It is probable that Sweetser had read Feuchtersleben before writing his own book, since several parallel passages appear in both works, but it must be said that Sweetser's approach was entirely different.²

Sweetser's work was by no means the first of its kind to appear in the United States, although it was the first to bear the title, *Mental Hygiene*. Several dissertations had been published here much earlier on the effects of the "passions" on bodily health and disease. One such essay, by H. Rose, had been printed in Philadelphia as early as 1794.

² I cannot forbear quoting a most interesting passage in Sweetser's last will and testament, filed February 13, 1875, shortly before his death.

"As an example to others, who can afford more ample bequests to their country, I give and bequeath all the real and personal property of said estate at the decease of Anna L. Sweetser, my wife, to the Treasury of the United States of America, to be applied toward the payment of the Federal National Debt incurred in defense and support of the Federal Union of said United States, this is all I can do for my country though I wish I could do more, for I feel that I owe it a much larger debt." Philip S. Sweetser, *Seth Sweetser and His Descendants* (Philadelphia, Integrity Press, 1938), p. 155.

By all odds the most popular of American works on psychosomatic medicine in the first half of the nineteenth century was a little book by Dr. Amariah Brigham, *Remarks on the Influence of Mental Cultivation and Mental Excitement upon Health*, originally published at Hartford, Connecticut, in 1832. It went through several editions in this country and was published also in London, Glasgow, and Edinburgh.

The author of this little book was later to become first superintendent of the New York State Lunatic Asylum at Utica. He was a member of the Original Thirteen who founded the American Psychiatric Association, and the founder and first editor of the *American Journal of Insanity*, which eventually became the official organ of the Association.

Brigham's book may be considered a pioneer American work in that aspect of mental hygiene known as child guidance.

The object of this work [he wrote in the preface] is to awaken public attention to the importance of making some modification in the method of educating children, which prevails in the present day. It is intended to show the necessity of giving more attention to the health and growth of the body, and less to the cultivations of the mind, especially in early life, than is now given.

Physical education, Brigham argued, was almost completely neglected in contemporary school curricula. This neglect, he declared, was no doubt occasioned by the mechanical inventions and discoveries which had rendered less necessary the employment of physical strength in man and had produced a general conviction that "knowledge *alone* is power."

Brigham was particularly alarmed by the lack of physical education for girls. He deplored, further, a trend in his time to stuff children with academic knowledge in the hope of developing them into intellectual giants.

I beseech parents, therefore, to pause before they attempt to make prodigies of their own children. Though they may not destroy them by the measures they adopt to effect this purpose, yet they will surely enfeeble their bodies, and greatly dispose them to nervous affections. Early mental excitement will serve only to bring forth beautiful but premature flowers, which are destined soon to wither away without producing fruit.^a

Brigham's book was replete with illustrations drawn from history of how famous child prodigies had ended up in early graves or in mad-houses. He also drew liberally from English and French medical literature to show interrelations between intellectual overactivity, emotional excitement, and disorders of the gastrointestinal tract.

^a Brigham, *op cit.* (3d ed., Philadelphia, Lea and Blanchard, 1845), p. 98.

One peculiarity of Brigham's work, as of many others dealing with the promotion of mental and physical health in his own and future generations, was its tendency to identify the life of the well-to-do with that of the general population. When Brigham wrote his book the public-school movement was in its infancy. Most children of the poor never went beyond the primitive three R's, and many had no schooling at all. The most serious obstacle to the healthy development of poor children—who represented the bulk of juvenile society in America—was not intellectual overexertion but physical overwork. Child labor was rampant. There were scarcely any laws to protect children from labor exploitation, and many a child toiled in daily shifts that would be considered too onerous for adult men in our day.

It is an interesting coincidence that the first notable discussion in American literature on the specific subject of mental hygiene, following the publication of Sweetser's book, appeared in the *American Journal of Insanity* in 1859, from the pen of Dr. George Cook. Cook was the superintendent of Brigham Hall, a private mental hospital in Canandaigua, New York, named after Amariah Brigham.

Cook contributed to the *Journal* a series of two lengthy articles, entitled "Mental Hygiene," and promised a third, "should other engagements permit the subject to be resumed." But the pressure of other work prevented the conclusion of the series.⁴ Unlike Sweetser's book, which stressed primarily the influences of mental and emotional activity on physical health, Cook's articles were concerned directly with the promotion of mental health and the prevention of mental disease—an approach similar to that of present-day mental hygiene.

While books abound giving minute directions as to what we may eat and drink, and wherewithal we should be clothed [he declared], we look in vain for any correct guide to the development and preservation of mental health. Hence a few words, hastily written amidst other pressing duties, may not be altogether unwelcome.⁵

Cook observed that histories of patients in mental hospitals disclosed that most cases of mental illness had their beginnings in early childhood. From this fact he concluded that the home must be made the focal point of mental hygiene. He charged neither legislators nor physicians, but parents, with the main responsibility for promoting mental health. He made

⁴ George Cook, "Mental Hygiene," *Am J Insanity*, XV (1859), 272-282, 353-365

⁵ *Ibid.*, p. 273.

many shrewd observations on the impact of bad family relationships on the mental health of children.

Very many American fathers are strangers to their children; they know nothing of their childish hopes and aspirations; they give them no sympathy, and receive in their turn distrust instead of confidence. How large is the proportion of the educated classes, of the active professional and business men, who never give even an infinitesimal fraction of their valuable time to the healthy mental and moral development of their children?

In another scathing rebuke to parents, he declared:

We would have the thoughtful reader consider well the blighting effects of parental hypocrisy, spreading out into an unconscious social hypocrisy, which pervades many homes; the absorbing worldly associations which thousands of parents throw around their children; the open skepticism which meet some on the threshold of life, and the dark stream of parental ignorance and vice, with its million of tributaries annually increasing in number. Bear in mind the various perverting social influences in this connection, and then sum up these numerous violations of the laws which regulate healthy mental and moral development, and you have the origin of one of the prevailing phases of American mind, distorted from its earliest years, prone to errors, weak, unguided, and often falling into utter ruin, the intellect borne down into hopeless obscurity by some of the worst forms of mental disease.*

Cook's articles were written at a time when state hospitals were springing up at an accelerated pace throughout the country. This institutional increase resulted in large measure from Dorothea Lynde Dix's crusade to get the insane transferred from common almshouses into hospitals for their special care and treatment. The growth of these institutions, together with the gradual development of more accurate methods of discovering and enumerating the mentally sick, resulted then—as it still does today—in an alarmist outcry that mental disease was spreading rapidly. A popular theory at the time was that the increasing complexity of civilized life was mainly responsible for the apparent increase in mental breakdowns.

Commentators on American life, both native and foreign, gave wide circulation to the notion that Americans were peculiarly susceptible to mental disorder. Various theories were advanced for this supposed state of affairs: the highly nervous tempo of the individual's daily routine in the United States; the fluidity and uncertainty of social relations where a man could be a pauper one day and a millionaire the next, the Yankee's

* *Ibid.*, pp 277, 281.

fierce love of freedom that rebelled against authority of all kinds, extremes in the American climate, weakening of spiritual strength in the mad pursuit of money and other materialistic objects, the flux of fortune in general. Dr. Cook's articles reflected the prevailing pessimism regarding the inevitability of an increase in mental disease as one of the penalties America had to pay for its democratic institutions.

The next notable American work on the subject was Dr. Isaac Ray's *Mental Hygiene*, published in 1863. Ray was another member of the Original Thirteen, and one of the most prominent psychiatric figures of the nineteenth century. He described the scope of his subject matter as follows:

Mental hygiene . . . may be defined as the art of preserving the health of the mind against all the incidents and influences calculated to deteriorate its qualities, impair its energies, or derange its movements. The management of the bodily powers in regard to exercise, rest, food, clothing and climate, the laws of breeding, the government of the passions, the sympathy with current emotions and opinions, the discipline of the intellect,—all come within the province of mental hygiene.⁷

Ray's book, in keeping with a growing trend of his time, was suffused with a crudely materialistic approach to mental disease, its causes and prevention. It reflected the popular influence of Thomas Buckle's stress on geography and climate as determining factors in the development of civilization. Dr. Ray indulged in lengthy discussions of these factors as contributing causes of insanity. He laid his main emphasis on the physiological and environmental influences on mental health.

Ray's emphasis on a materialistic approach to mental disease and its prevention was bitterly assailed in a lengthy review of his book that appeared in the *American Journal of Insanity* in 1863. The review was written by the *Journal's* editor, Dr. John P. Gray, superintendent of the New York State Asylum at Utica. Gray was a man of strong opinions, with violent likes and dislikes. He was certainly the most active polemicist in the history of American psychiatry, and was frequently embroiled in several major controversies at once. Indeed, Gray was often charged with using the *Journal* as an organ of personal expression. Certain it is that the *Journal* strongly reflected the impress of his personality during his long period of editorship (1854–1884).

Gray's review was largely devoted to a criticism of Ray's deterministic

⁷ *Op. cit.* (Boston, Ticknor and Fields, 1863), p. 15.

approach to his subject. The editor sternly rebuked the author for leaving out free will and other metaphysical tenets from his mental hygiene system.

His doctrine [Gray wrote] is that the mental phenomena have only one origin, the physical organization, whence it follows there can be but one mode of treating them, which is from the side of natural laws. This is simply the doctrine of the old phrenologists, and is, we think, fairly exploded and obsolete.^a

Thirteen years later, however, Dr. Gray had occasion to approach closely the position that he had so roundly criticized in 1863. In a paper entitled "Mental Hygiene,"^b read before the International Medical Congress held at Philadelphia in 1876, Dr. Gray said: "We must start with the proposition that what is now denominated Mental Hygiene, is practically inseparable from Physical Hygiene. It is comparatively a new application of the word hygiene."

Gray then went on to quote, with approval, a passage from Dr. Henry Maudsley's *Gulstonian Lectures* for 1870.

The metaphysician may, for purposes of speculation, separate mind from body, and evoke the laws of its operation out of the depths of self-consciousness; but the physician who has to deal practically with the thoughts, feelings and conduct of men, who has to do with the mind, not as an abstract entity, concerning which he may be content to speculate, but as a force in nature, the operations of which he must patiently observe and anxiously labor to influence, must recognize how entirely the integrity of the mental functions depends on the bodily organization, must acknowledge the essential unity of mind and body.

In this paper, Gray broadened the concept of mental hygiene far beyond the narrow limits of personal application to which it had been largely relegated in previous discussions. Mental hygiene is not only related to individual life, he said; there is also a "mental hygiene in communities," which necessitates that students of mental hygiene enter "the wide domain of sociology and social science."

Mental hygiene may be variously classified, but, as a whole, it embraces all that relates to the development, exercise, and maintenance of mental activity in individuals, communities and nations, and must, therefore, be considered from an individual, social, and national point of view. It involves education,

^a "Mental Hygiene" (a review), *Am. J. Insanity*, XX (1863), 342.

^b *Am. J. Insanity*, XXXIV (1878), 307-341.

social culture, religion and national life . . . Mental hygiene covers all the broad field of human energy, embracing all the professions and every branch of industrial life.

By this time (1878) the term "mental hygiene" had passed into more or less general use. While various shades of meaning were given it, the term was now widely accepted as encompassing the prevention of mental disease and the positive promotion of mental health.

It was not until the twentieth century that the term became indelibly associated with *organized* efforts to promote mental health, more specifically, with the mental hygiene movement. It is in this sense of organization that the term "mental hygiene" will be used hereafter in this chapter.

It may be profitable, before launching upon a discussion of the movement founded by Clifford W. Beers, to describe at some length the adventures of a forerunner of that movement which, though brief and abortive, yet contributed no small amount to the progress of American psychiatry. I refer to the little known and less appreciated National Association for the Protection of the Insane and the Prevention of Insanity (NAPIPI), which was born in 1880 and passed quietly out of existence a few years later.

The origin and development of this short-lived organization took place in a historical setting highly significant for the future of psychiatry and allied sciences. The period was one marked by a decided trend toward organizations aimed in large measure at the prevention of social and medical ills. The American Public Health Association was organized in 1872, the State Charities Aid Association of New York, which was to play a leading role in the state care movement for the insane, was founded in the same year. The National Conference of Social Work, which served as the matrix for the abortive mental hygiene movement of the 1880s, was started in 1874. The Charity Organization Society movement got under way three years later.

In many ways, the National Association for the Protection of the Insane and the Prevention of Insanity was more significant for the events and conditions leading up to its establishment than for its actual activities. The first suggestion for forming such a society in this country was advanced as far back as 1845 in the *American Journal of Insanity*. Yet this very journal was to become the chief organ of the bitterest critics of the association, when it was actually organized thirty-five years later.

In 1845 the *Journal* carried a notice describing the organization in

London three years earlier of the Society for Improving the Condition of the Insane. The notice, signed by Dr. Pliny Earle (one of the Original Thirteen), pointed out that the English society was headed by the great social reformer Lord Shaftesbury, and that its major aims, as set forth in its constitution, included: "The diffusion of practical knowledge concerning the nature, causes and treatment of Mental Disorder, by meetings of Medical Practitioners, and other persons who feel interested in the subject, in London and its vicinity."¹⁰

This English organization urged the creation of a national lunacy commission with power to visit and inspect all public and private mental hospitals in Britain, and to supervise the general institutional care and treatment of the insane. Lord Shaftesbury introduced a bill to this effect in Parliament, and it was enacted into law in 1845, the year in which Dr. Earle's notice appeared.

In his short account of 1845, Dr. Earle appended this significant question: "When will a similar association be formed among the dignitaries of this land?"

It was not until a generation later that such a society—the aforementioned National Association for the Protection of the Insane, etc.—was finally organized here. The creation of the National Association in 1880 represented the climactic convergence of several significant trends.

The first phase of the reform movement encompassed as its main goal the transference of mental patients from poorhouses and prisons—where most of them were confined during the greater part of the nineteenth century—to institutions for their special care and treatment. Dorothea Lynde Dix's forty-year crusade, beginning in 1841, was principally devoted to the goal of building enough "insane asylums" to accommodate all the mentally sick then confined in penal and pauper institutions. One of the most effective propaganda devices utilized by Miss Dix in her great crusade was the contrast of the widely prevalent brutality toward and neglect of the mentally sick in almshouses with the humane, therapeutic atmosphere of the few mental hospitals in operation at the time. To impress people with the economic as well as the humane benefits of constructing more mental hospitals, Miss Dix frequently cited statistics from American institutions which tended to show that nearly all mental patients could be cured in special hospitals if sent there in the early stages of the disease.

¹⁰ *Am J Insanity*, II (1845), 91-92.

Her greatest work was done during the thirty-year period when what I have called elsewhere the "cult of curability" raged through the land.²¹ The cult developed from the utterly unfounded supposition that in its early stages mental disease was easily curable with the therapeutic devices already at hand. Asylum superintendents gave currency to this notion by presenting, in their annual reports, highly-exaggerated claims of cures. In the 1840s, at the height of the curability craze, it was not uncommon for asylum heads to claim the recovery of 90 per cent and more of their "recent cases." In at least one case, 100 per cent cure was claimed.

The uncritical accepted these claims at their face value. Mental hospitals, in the minds of many, were enveloped with a mystic aura. They were imbued with the magic qualities of the healing temples of ancient times, and were considered capable of curing most patients who entered their sacred precincts.

When the inevitable happened and the curability bubble finally burst—largely through the exhaustive reexamination of institutional statistics conducted by Dr. Pliny Earle in the 1870s—disillusionment caused the pendulum of public opinion to swing violently from extreme optimism to reassertion of the old adage: "Once insane, always insane." This revulsion of feeling reacted against the "insane asylums" themselves. Moreover, occasional public inquiries into the management of mental hospitals revealed increasing evidence of gross abuses in these once sacrosanct institutions. Friends of the insane shifted their main point of attack from poorhouses to mental hospitals. Diminution of faith in the curative powers of mental hospitals stimulated still another shift in emphasis. With the realization that only a small percentage of mental patients were being cured even in the best-conducted institutions, increasing numbers of medical men and social reformers turned their attention to the possibilities of the preventive approach to mental disease.

There developed at this time too, coincident with the growth of the democratic ideal, a wide public interest in the personal rights of the insane. How far was the state justified in depriving of their liberty and forcibly incarcerating persons who had committed no crime?

In the Sixth Annual Report of the Massachusetts State Board of Charities, Dr. Samuel Gridley Howe, the great pioneer in American social

²¹ I have described at length the origin and development of this fantastic cult in my book, *The Mentally Ill in America* (Garden City, N. Y., Doubleday, Doran, 1937)

welfare, stated succinctly the problem which was disturbing many democratic minds:

Yes, disguise it as we may, we do keep under unnecessary restraint and in a sort of slavery, a multitude of unfortunates who sigh for liberty, and to whom it would be sweet. . . .

It would be folly to deny that restraint by walls, by iron sashes, by oaken doors and by constant guard is necessary for a certain class of patients under our mode of treatment. But it is equal folly to maintain that it is necessary for all, or for nine-tenths; and if it is not necessary, upon what ground can we defend our violation of a right which the lunatic never forfeited?

It is sinful and criminal to abridge unnecessarily the freedom of an innocent man; and it is, moreover, cowardly and cruel to abridge that of an unfortunate lunatic.¹²

Another important element in the changing picture was the rapid rise of neurology as a profession following the Civil War. In hardly more than a decade after the end of the conflict between North and South, the infant profession of neurology claimed such eminent members as:

WILLIAM A. HAMMOND (1828-1900), who had served as Surgeon General of the Union Army for the greater part of the War.

S. WEIR MITCHELL (1829-1914), renowned medical author and inventor of the "rest cure," who had been drawn to neurology as a result of his experience in treating nerve wounds during the War.

EDWARD C. SEGUIN (1843-1898), son of the famous pioneer in the care and treatment of the feeble-minded, prominent in his own right, who shared with his father a zeal for social reform that was combined with his mastery of a medical specialty.

EDWARD C. SPITZKA (1852-1914), an American pioneer in neurophysiological research who also gained a reputation as a medicolegal expert.

GEORGE M. BEARD (1839-1883), an extraordinarily prolific writer on neurological and other medical topics, who is remembered chiefly for his contributions to the concept of neurasthenia.

J. S. JEWELL (1837-1887), of Chicago, who founded in 1874 the *Journal of Nervous and Mental Disease*, which soon became the chief organ of the neurological profession in America.

The founding of the New York Neurological Association in 1872 highlighted the early organizational growth of the profession. Hardly had this war-created profession reached an organized plane than it became em-

¹² Massachusetts State Board of Charities, *Sixth Annual Report* (for 1869), p. lxxxvii.

broiled in a long and bitter feud with the earlier organized medical superintendents of mental hospitals.

Most of the pioneer neurologists were private practitioners or teachers in medical schools, a good proportion of them were intensely interested in scientific research. This was especially true of the remarkably brilliant constellation of talented men who led the profession—men like Mitchell, Beard, Seguin, Spitzka, and Hammond. The leadership of the Association of Medical Superintendents of American Institutions for the Insane, on the other hand, was composed of men grown old in institutional service.

The neurologists charged the institutional superintendents with failure to encourage research among their medical staffs, with an autocratic and narrow-minded attitude toward the management of their asylums, with placing too many unnecessary restraints upon the liberties of their patients, and with maintaining the Association as a closed corporation which excluded from membership not only noninstitutional psychiatrists or neurologists but even institutional specialists who had not yet risen to the rank of superintendent. The neurologists charged, further, that the asylum heads ran their institutions more like boarding homes than hospitals, displaying more interest in plumbing and heating apparatus than in active therapeutic measures.

The medical superintendents, on their part, retorted that the neurologists were engaged in an insidious campaign to discredit insane asylums in the public mind, so as to divert patients from hospitals to the private offices of neurological practitioners. The *Journal of Nervous and Mental Disease*, in the decade following its first appearance, served as a prominent organ for the medical criticism of mental hospital management. The *American Journal of Insanity*, in turn, violently opposed what came to be known as the "asylum reform movement."

The major momentum for the movement that led to the creation of the National Association for the Protection of the Insane and the Prevention of Insanity came from an alliance of convenience between neurologists and social workers. The latter for years had had the opportunity to study the social and economic consequences of mental disease in the homes of the afflicted. Social workers of necessity approached the subject from the viewpoint of dependency rather than disease. They came into firsthand contact with the mentally sick in the poorhouses. They were in the forefront of the movement to get the insane out of almshouses into special hospitals, and to introduce humane treatment in such hospitals as already

existed. They were among the first to realize the great social and economic benefits accruing from a program for preventing mental disorder.

It is significant that the very first meeting of the National Conference of Social Work (then known as the Conference of Boards of Public Charities), in 1874, was largely devoted to the subject of insanity and its treatment. Dr. John B. Chapin, superintendent of the Willard State Asylum at Ovid, New York, read the first paper, in which he urged complete state responsibility for the care of all the indigent insane.¹³

At the 1876 Conference, Dr. Hervey B. Wilbur, superintendent of the New York State Asylum for the Feeble-Minded at Syracuse, read a widely discussed paper on "Government Supervision of the Insane." Dr. Wilbur was one of the most eminent institutional psychiatrists of his time, the founder of the first school for mental defectives in the United States (opened at Barre, Massachusetts, in 1846), and head of the Syracuse State Asylum from its establishment in 1851.

Dr. Wilbur's paper was based mainly on a personal survey of English mental hospitals and a study of the operation of the English Lunacy Board. He alternated high praise for the English supervisory system with condemnation of the unsupervised isolationism of American institutions. The United States, he declared, lagged far behind England in creating adequate governmental protection for the mentally sick. Urging the creation of state-wide boards of lunacy on the English model, Dr. Wilbur charged the asylum superintendents' organization with chief responsibility for blocking efforts toward that goal.

The only opposition that has been made to the project has come from parties directly connected with the management of insane asylums. For years they have placed themselves in opposition to a public need and a public want. Banded in an association known as the American Association of Medical Superintendents of Insane Asylums, a closed corporation that excludes from fellowship any assistant medical officer of however large experience or faithful service, it not only assumes to dictate to legislative bodies what laws are necessary in the case of the insane, but claims, for a small class of medical specialists, the sole privilege of the interpretation and application of these laws.¹⁴

Dr. Wilbur might have added that he himself, although frequently invited to attend annual meetings of the Association and occasionally a

¹³ Chapin, "The Duty of the States toward the Insane Poor," Conference of Boards of Public Charities, *Proceedings* (1874), pp 5-7.

¹⁴ Wilbur, "Governmental Supervision of the Insane," *ibid.* (1876), p. 81.

speaker on its program, had been barred from membership on the ground that the care and treatment of the feeble-minded was outside the realm of the psychiatric profession.

By 1876 the Conference of Charities had become the main forum for the "asylum reform" movement. At its 1878 annual meeting it heard an important address by Dr. Nathan Allen (1813–1889), a leading figure of the movement who had been a prolific contributor to medical literature, especially to that on mental diseases. At the age of twenty-six, while still an undergraduate in a medical school, he had served as editor of the newly founded *American Phrenological Journal*.

Bearing the ambitious title, "The Prevention of Disease, Insanity, Pauperism and Crime," Dr. Allen's paper at the 1878 Conference concentrated mainly on insanity. Allen quoted the pessimistic opinion of Sir James Coxe on the curability of mental disease, rendered a year earlier before a Parliamentary investigating committee. "The fact is indisputable," Coxe had testified, "that as the case actually stands, asylums are places of curative treatment for only 10 percent of their inmates, and mere places of detention or safe custody for the remaining 90 percent."

"The statement here made respecting the asylums of Great Britain applies, we fear, with equal force to the insane of this country," Allen observed. "What a powerful argument does this fact present in favor of using all possible means for the prevention of the malady!"¹⁵

How could a preventive program best be carried out? "For the prevention of insanity," said Allen, "the same course must be pursued as with reference to other diseases. Ascertain its causes, diffuse information on the subject. This may be accomplished in a variety of ways—by enlisting the press, through journals and books, by family and educational training, by legislation and associated action."

Admitting that but few concrete data on the prevention of mental disorders were yet available, Allen insisted that these few should be disseminated through regular channels of public information, and that more could be revealed as the causes of insanity were more intensively studied.

By this time American mental hospitals were being subjected to an unceasing, concentrated barrage of criticism in professional and popular journals. Leading neurologists were pacing the attack on the prevailing system of managing institutions for the insane. Social reformers like Dorman B. Eaton and George W. Curtis, famous for their pioneering work in

¹⁵ Allen, *op cit.*, *ibid* (1878), p. 87.

civil-service reform, also entered the fray against the embattled asylum superintendents.

In 1878, and again in 1879, the New York Neurological Society presented formal petitions to the New York State Legislature, demanding an investigation of the asylum system in that state. In May, 1879, the State Legislature's committee on public health held hearings on the Neurological Society's petition. The hearings resulted in a report absolving the state hospitals from the charges of mismanagement and abuses cited in the petition.¹⁶ A cry immediately went up that the committee had "white-washed" the institutions.

That same year the Legislature defeated by a narrow margin a bill creating a state lunacy commission in New York, in place of the one-man lunacy commissioner, Dr. John Ordronaux, who had held the office since its establishment in 1873. Ordronaux had long been criticized by the reform group as negligent and overtolerant of asylum abuses.

The Legislature's action did not discourage the New York reform group. Under its auspices a mass meeting was held at Cooper Union in New York City in December, 1879. George W. Curtis presided, and Drs. Edward C. Seguin and Edward C. Spitzka addressed the meeting. Several resolutions were adopted, including one urging the creation of a state lunacy commission patterned after the British model. Another resolution declared: "That this meeting also earnestly recommends the organization of a National Association for the Protection of the Insane, and that the Committee here appointed take steps for the formation of such an Association."¹⁷

The said committee was duly appointed; it consisted of William C. Church, Dorman B. Eaton, Dr. George M. Beard, and Dr. E. C. Seguin. As a result of their efforts, the reform movement reached its culminating point at the annual meeting of what was then called the Conference of Charities and Correction, held in Cleveland in 1880. A special session on lunacy at the Conference heard Drs. John C. Shaw, Nathan Allen, George M. Beard, and E. C. Seguin deliver addresses on different aspects of the lunacy reform movement.

In an impressive paper on "Why We Need an Association for the Protection of the Insane," Dr. Beard declared that such a society, if formed,

¹⁶ New York State Legislature, Committee on Public Health, *Report Relative to Lunatic Asylums*, May 22, 1879 (Albany, C. Van Benthuysen and Sons, 1879).

¹⁷ *Report of the Proceedings for Establishing a Board of Commissioners in Lunacy, for the State of New York* (New York, A. G. Sherwood & Co., 1880), p. 3.

could protect the interests of the insane by mobilizing public opinion behind the movement to create central state supervisory boards, by stimulating research into the causes, cure, and prevention of mental disease, and by promoting a better public understanding of the subject through the diffusion of sound information.

This society will have justified its existence [he declared], if it shall succeed in doing nothing but this—in obtaining universal recognition of the fact that it is no disgrace to be crazy.

Through all the sources of information we are to seek light on this problem—how to prevent insanity, how to reduce to a minimum the friction of modern life.²⁸

On July 1, 1880—the day following this special session—the National Association for the Protection of the Insane and the Prevention of Insanity was formally organized in Cleveland. A constitution was forthwith drawn up, stating six methods by which the society would strive to achieve the objects implicit in its name:

First. By the encouragement of special and thorough clinical and pathological observations of the medical profession generally, as well as [of] those [doctors] connected with asylums

Second. By enlightening public sentiment as to the nature of the malady, the importance of early treatment, improved methods of management and treatment at home and abroad.

Third. By recommending an enlightened State policy, which, while neglecting no one of its insane population, shall so administer relief and protection as not to lay unnecessary burdens upon the tax-payers

Fourth. By holding public meetings, wherever needed, to stimulate legislation that will secure efficient State supervision of all public institutions for the care of the insane, as a mutual safeguard for the protection of society—the patients, as well as those who have them in charge

Fifth. To further the protection of laws relating to the treatment of the insane, and their rights while patients in the asylum.

Sixth. By efforts to allay the public distrust in relation to the management of insane asylums, by placing them on the same footing as that of other hospitals, both in the matter of freer communication with the outside world, and the privilege of a consulting medical staff of general practitioners.

Curiously enough, this series of stated objectives omitted any reference to one of the two general aims explicit in the society's name—the preven-

²⁸ Beard, *op cit*, Conference of Charities and Correction, *Proceedings* (Boston, Tolman & White, 1880), p. 149

tive approach. This omission was rectified in 1883, when the second objective was amended to read. "The enlightenment of public sentiment as to the nature of the malady, *the means of prevention*, the importance of early treatment, improved methods of management and treatment at home and abroad."¹⁹

The first officers elected at the founding meeting at Cleveland were Dr. Hervey B. Wilbur, President; Dr. Nathan Allen, Vice-President; Miss Alice A. Chevaillier (a social worker of Boston), Secretary; and Dr. George M. Beard, Treasurer.

A Council of the National Association was also formed, consisting originally of seventeen members, nearly all of whom were physicians. Among them were Dr. Mary Putnam Jacobi, wife of the great pediatrician and herself a famous woman pioneer in medicine; Dr. John C. Shaw, a young neurologist who had been made medical superintendent of the Kings County Lunatic Asylum in Brooklyn, where he practically abolished mechanical restraint; Dr. Joseph Parrish, head of the New Jersey State School for the Feeble-minded at Vineland; Dr. J. S. Jewell, founder and editor of the *Journal of Nervous and Mental Disease*; and Dr. E. C. Seguin. Any person could become a member of the Association upon payment of a two dollar annual membership fee.²⁰

The NAPIPI got off to a flying start. The time was ripe, and the temper of the people receptive, for an organization with its avowed principles. There was widespread dissatisfaction with the prevailing institutional care and treatment of the mentally sick. This public sentiment arose partly from a knowledge of real defects, partly from the sensational, overdrawn "exposés" of individual asylums which were then common in newspapers and popular magazines. Apart from the matter of "asylum reform," there was a genuine public interest in the possibilities of preventing mental disease.

The NAPIPI received the blessing of the American Neurological Association and the editorial accolade of the *Journal of Nervous and Mental Disease* immediately upon its founding. It rallied to itself the support of many individual neurologists, a still larger number of social workers,

¹⁹ "Abstract of Minutes of the Meetings of the Association, Held in Philadelphia, January 25th and 26th, 1883," *Am Psychol. J.*, I (1883), 95, 97

²⁰ National Association for the Protection of the Insane and the Prevention of Insanity, *Constitution, By-Laws, etc* (Boston, Tolman and White, 1880), pp. 4-5.

many general practitioners, some institutional psychiatrists, and even several mental hospital superintendents who were in rebellion against the official policy of the Association of Medical Superintendents.²¹

The NAPIPI trained all its big guns against the asylum superintendents and their organization. In New York State, where the NAPIPI had its main strength, it succeeded, in collaboration with the New York Neurological Society, in getting the Legislature to make four investigations of the state hospital system within a period of five years. The main object of their attack was Dr. John P. Gray and the institution he headed, the Utica State Asylum.

The nature and violence of the reform movement's attack may be gauged by the tenor of an extremely influential article in the *North American Review* of 1881 from the pen of Dorman B. Eaton, one of the founders of the NAPIPI. The *Review* was then one of the most popular magazines in the country.

Eaton's article, entitled "Despotism in Lunatic Asylums," vividly reflected the prevailing alarmist mood regarding the institutional care and treatment of the insane. The particular villains of his piece were the asylum superintendents. Eaton made no discrimination between good and bad executives, good and bad institutions, all were tarred with the same heavy brush he furiously wielded. The resulting picture was doleful in the extreme. Insanity was increasing at an alarming rate in the United States, Eaton observed. Palatial asylums (it was a period of extravagant, Victorian ornamentation in public buildings) had failed utterly to check mental illness. Erected in the hope of supplying the needs of a generation, the asylums were barely able to hold the numbers of insane that poured into their doors as soon as they were opened.

Humanity, statesmanship, self-preservation, therefore, demand that the grave question of insanity be brought forth from the filth and politics of the poor-houses, and from the secrecy, the mystery and the professional metaphysics of the asylums and the doctors, and set up in the forum of public debate and criticism. It is none too soon that, this year, a national association for the protection of the insane and the prevention of insanity has been formed . . . and that

²¹ Among the heads of psychiatric institutions who became active members of the NAPIPI were Drs. John S. Butler of the Hartford Retreat, William W. Godding of St. Elizabeths Hospital in Washington, Walter Channing of the Channing Sanitarium, H. H. Bannister of Kankakee, Charles K. Mills of Philadelphia, Alice Bennett of Norristown, and Margaret A. Cleaves of Davenport, Ia.

the mysterious abuses within the walls of our asylums and the lunatic wards of poor-houses are more and more receiving the attention of the public press.²²

Eaton further charged that in the absence of an efficient system of central lunacy supervision, too much power was entrusted to the trustees of individual insane asylums.

. . . As private owners of the institution, they could not have power more absolute and irresponsible. The most ordinary and essential checks upon extravagance, favoritism, and neglect are utterly wanting.

But the authority of the asylum superintendent is, if possible, more dangerous and unchecked than that of the trustees. He is an autocrat—absolutely unique in this republic—supreme and irresistible alike in the domain of medicine, in the domain of business, and in the domain of discipline and punishment. He is the monarch of all he surveys, from the great palace to the hencoops, from pills to muffs and handcuffs, from music in the parlors to confinement in the prison rooms; from the hour he receives his prisoner to the hour when his advice restores him to liberty. . . .

This unparalleled despotism—extending to all conduct, to all food, to all medicine, to all conditions of happiness, to all connection with the outer world, to all possibilities of regaining liberty—awaits those whose commitments may easily be unjust if not fraudulent, whose life is shrouded in a secrecy and seclusion unknown beyond the walls of an insane asylum.

Eaton went on to depict the rest of “asylum despotism” in America in equally somber colors. In contrast, he painted an idyllic picture of British mental hospitals under the benign guidance of the National Lunacy Board, which had been established in 1845.

This Board, Eaton pointed out, consisted of eleven members—three doctors, three lawyers and five “men of business”—who regulated, visited and inspected all institutions for the mentally sick in Britain, public and private alike. Pages might be filled with proofs of the good influence of the Board, Eaton added. His glowing panegyric of the asylum system in England—“no more despotism, no more secrecy, no more extravagance, no more lobbying, no more asylum politics”—must have amused many an Englishman, in view of the fact that Britain at that moment was experiencing a heated public debate over asylum abuses, and charges of impotency and laxity were being leveled against the Lunacy Board. These charges almost resulted in the resignation of the venerable Lord Shaftesbury from the chairmanship of the Board, a post he had held for thirty-five years. •

²² Eaton, “Despotism in Lunatic Asylums,” *North Am. Rev.* (1881), pp. 263-275

Eaton's strong indictment of the "American asylum system" was widely quoted in the popular press, and in certain medical periodicals. It was answered by Dr. Orpheus Everts, superintendent of the Cincinnati Sanitarium, in a paper read at the annual meeting of the Association of Medical Superintendents in June, 1881, and later printed in the *American Journal of Insanity*.²⁸

Dr. Everts swiftly traced the rise and decline of mental hospitals in the public esteem. The transference of mental patients from poorhouses to asylums had in itself elicited public approval as a progressive step. The statistics of the early hospitals showing high recovery and improvement rates had "magnified the reputation of hospital physicians, and exalted these institutions in popular estimation." But, he added,

. . . the number of recoveries and deaths never quite equalled the number of insane persons admitted to [the institutions]. A gradual yet inevitable accumulation of the chronic and incurable class in hospital population affected their reputation unfavorably as agencies of cure.

A wonderful increase of population, natural and by immigration, produced applicants for public care and treatment more rapidly than the States could well make provision for them. Besides all this, accommodation was demanded for multitudes of variously incompetent persons, who had not previously been recognized as insane, at least not so affected as to need hospital care.

Insanity itself appeared, on a superficial glance, to increase in an undue ratio to population, and seemed to be less curable

Taking direct cognizance of the list of indictments drawn up in the Eaton article and in various editorials of the *Journal of Nervous and Mental Disease* as a reflection of public disillusionment, Everts proceeded to loose barbs of ironic scorn at the motley critics of the "asylum system."

To impute the worst characteristics of human nature to those most prominently employed in hospital affairs has become to a degree fashionable. To accuse managing boards of dishonesty, and medical superintendents and subordinates of incompetency, or criminal neglect of duty and abuse of authority toward helpless "prisoners" is a common feature of public scandal.

Benevolent persons who, in their zeal, do not always distinguish between feeling and judgment, and are apt to accept earnest assertion for indisputable facts, have been moved to a pity and indignation by the recital of such constantly repeated accusations

Men and women of intellectual and social distinction who may have themselves (unhappily) suffered the humiliation, and possibly some errors, of hospi-

²⁸ XXXVIII (1881), 113-139

tal treatment, after apparently recovering the use of their faculties, have given tone and color of veracity to stories of ill-usage, and vigorous expression to mental concepts of hospital administration, tinged by memories and imaginations, the morbid parentage of which may be unsuspected by others or even by themselves.

Born agitators and "professional reformers," who live and move upon the borderland of insanity, being native there, or revolve on their own axes—who are ever intent upon turning the world upside down, and having things done some other way, no matter what the present way may be—have appropriated all such suspicion, imputation, accusation and scandal as valuable contributions to their magazine of munitions, to be used in a general crusade against whatever appears to be established.

Professed neurologists and flippant neurospasts of the medical profession, arrogating to themselves all knowledge of psychology and psychiatry, have by sneers, innuendo, and direct assault upon the character and qualifications of medical officers serving in American hospitals for the insane, done what they could toward the disparagement of hospital reputation.

Hungry politicians of a low order, on the accession to power of a party which they had served, clamorous for a "change," have in notable instances unscrupulously manufactured and promulgated accusations and reports as testimony against incumbents of hospital places, calculated to disquiet and abuse the public mind respecting the management of these great charities. Foreign hospitals and their methods have been extolled and contrasted as in every respect superior to our own . . .

An association calling itself national has been gotten up ostensibly "for the protection of the insane and the prevention of insanity," but really for the purpose of concentrating and organizing hostility to present institutions and present methods, so far as they have been approved by a majority of those who have been or are engaged in administering them.

This organization, which is not without talent and respectability, is seconded in its movements more or less by influential members of the medical and scientific press, and a miscellaneous support among the magazines and newspapers of the day.

Admitting defects in the American mental hospital system, and the inevitable presence of errors and abuses, Dr. Everts vigorously defended his fellow asylum superintendents against the general charges of their detractors. He upheld the opinion of the great majority of institutional heads, that the total abolition of mechanical restraint was not feasible. He insisted that such restraints were often more humane than the manhandling by attendants, and superior to many forms of chemical restraints. He readily admitted that neglect, cruelty, and deception sometime occurred in American asylums, but added that such instances were

relatively rare: "More insane persons are ill-treated, injudiciously restrained, neglected and otherwise abused while among friends in the family relation, than suffer from similar treatment in the least reputable insane hospital in America, proportionately considered."

Turning to the insistent public demand for creation of state lunacy boards to supervise the care and treatment of the insane, he retorted:

The proposition of "American reformers" to convert the limited and responsible autocracy of present methods into an aristocracy of hospital officials of various grades, who, appointed by American methods, would become either more despotic and irresponsible by combining in a common interest, or disastrously weak and inefficient by dissensions and antagonism, does not promise well to comprehensive and considerate minds.

An extended and at times heated discussion followed the reading of Dr. Evert's paper at the Association of Medical Superintendents meeting. Dr. Richard Gundry of the Maryland State Hospital at Catonsville ventured to suggest that some of the criticism against mental hospitals and their administrators was justified. He added that the wisest course was to adopt constructive recommendations as "inner reforms" to forestall drastic reforms, including destructive measures, that might be forced through outside pressure upon those assembled. He boldly came forth as an advocate of central lunacy boards, which must have marked him as a heresiarch among the old stalwarts of the Association who stood foursquare against supervision by outside "meddlers."

Gundry was immediately subjected to the blistering counterattack of the most vociferous psychiatric polemicist of them all, John P. Gray of Utica. Gray decried the hospital critics as "malcontents" and "perturbators," and chided Dr. Gundry for succumbing to their "propaganda." Observing that he and his institution at Utica were special objects of the "asylum reformers' " attacks, Gray assailed his critics as numbskulls and scoundrels bent, for the most part, on personal vengeance. He was particularly scornful of Dr. Gundry's advocacy of state lunacy boards, charging that the laws of New York State provided the mentally sick with fully as many effective safeguards against maltreatment as the English lunacy law.²⁴

During the next few years stormy debates raged over the question of "asylum reform" in popular and professional journals. Abusive attacks

²⁴ "Proceedings of the Association of Medical Superintendents," *Am J Insanity*, XXXVIII (1881), 186-252.

filled the atmosphere. Asylum heads were assailed by the neurologist-reformer groups as "despots," "autocrats," "reactionaries," and "business men who had lost interest in medicine and science." Their institutions were referred to as isolated "monasteries of the mad," as "prisons" behind the wall of which insane victims were subjected to unspeakable cruelties and horrors. Their organization, the Association of Medical Superintendents, was dubbed a "closed corporation," a "mutual admiration society." On their part, the medical superintendents loudly and frequently expressed contempt for the "reformers," the "outside meddlers," the "soft-headed humanitarians," and the "neuropaths" whose attacks were motivated either by ignorance or self-interest. The debate—or rather feud—reached depths of personal abuse seldom equaled in American medical history, even in the later epoch which marked the great controversy over Freud and psychoanalysis.

In the meantime, the noninstitutional neurologists and psychiatrists were already making a bold bid for primacy in the field of treating the mentally sick. In 1879 Dr. William A. Hammond had crystallized the private practitioners' revolt against institutionalism in a paper on "Non-Asylum Treatment of the Insane," read before the New York State Medical Society.

It is the commonly accepted opinion among physicians and the public generally [Hammond said] that as soon as possible after an individual becomes insane, he or she must be at once placed under the restraint of a lunatic asylum. No matter what the type of mental aberration, no matter what the facilities for receiving care and attention at home, the asylum is regarded as the necessary destination of the one so unfortunate as to be deprived wholly, or in part, of the light of reason.

For this state of affairs the medical officers of insane asylums are mainly responsible, for they have diligently inculcated the idea that they alone, by education, by experience, and by general aptitude, are qualified to take the medical superintendence of the unfortunate patients in question, and that restraint and separation from friends and acquaintances are measures in themselves which are specially curative in their influence.

Hammond challenged this supposition as unfounded in fact. Most mental patients, he averred, could be treated better, or at least as well, in their own homes by general practitioners or by noninstitutional specialists. In support of his argument, he stated (erroneously) that Benjamin Rush, father of American psychiatry, had never been connected with a mental hospital. He noted that, among his contemporaries, Cly-

mer, Seguin, Spitzka, and Beard in New York, S. Weir Mitchell in Philadelphia, and J. S. Jewell in Chicago were all "assiduously giving attention to the science and art of psychiatry and all unconnected with lunatic asylums."²⁶

The mild cases of "insanity" (cases that would now come under the general heading, "psychoneuroses") were especially amenable to home treatment, said Hammond. His paper was replete with inaccurate and exaggerated statements, such as "It is established by the evidence of experienced men that nine cases of insanity out of ten recover if placed under treatment within three months after the attack"—a reiteration of the curability myth. But the significant point in this paper is that Hammond most forcefully expressed a growing body of opinion that mental patients might fare better under treatment in their own homes or "family care" than under institutionalization.

Mutual mudslinging was common during this period of intense antagonism between the institutional psychiatrists, on the one hand, and the noninstitutional neurologists, psychiatrists, and social workers on the other. The controversy over asylum reform reached far beyond its original precincts and extended to practically every phase of psychiatric activity.

Personal feuds of fantastic bitterness developed, as witness that between Dr. Eugene Grissom, superintendent of the North Carolina State Insane Asylum at Raleigh, and Dr. William A. Hammond. Dr. Grissom, a stalwart of the Association of Medical Superintendents, had read a paper on "True and False Experts" before the Association's annual meeting of 1878. Starting out as a general discussion on expert psychiatric testimony in criminal trials, the paper wound up as an attack upon the personal character and professional standing of Dr. Hammond, couched in terms of crude invective seldom paralleled in the literature of medical feuds.

Grissom characterized Hammond as the very epitome of the "false expert," citing specific criminal cases wherein Hammond allegedly had "testified falsely." He proceeded to depict Hammond as

a man so lost to conscience and honor as to inflict almost irreparable damage upon the science of medical observation . . . with heart of iron and forehead of brass . . . a Bombastes Furioso of false experts . . . the type of a reckless class

²⁶ William A. Hammond, *Non-Asylum Treatment of the Insane* (New York, Putnam's, 1879), pp. 1-4

of men who are attempting to control the medical and even the secular press of the country, and to poison the public mind until they shall have worked upon popular ignorance and passion, as they hope, to the destruction of the present system of providing for the insane in the United States.

Grissom concluded his statement on Hammond with this melodramatic indictment: "Now at last we shudder as we recognize that the false expert is no man at all, but a moral monster, whose baleful eyes glare with delusive light; whose bowels are but bags of gold, to feel which, spider-like, he casts his loathsome arms about a helpless prey."²⁸

Grissom's address, published in the *American Journal of Insanity* and later reprinted as a pamphlet, evoked an immediate, and a bitter, response from Hammond in the form of "An Open Letter to Eugene Grissom," which was widely distributed.

No sooner had Hammond's reply appeared than Grissom jumped into the fray again with a "Rejoinder," filled with even more invective than his first attack, and including as evidence against Hammond lengthy quotations from the court-martial decision of 1864, which had found Hammond guilty of charges of malfeasance and misconduct while serving as Surgeon General of the U. S. Army. (Shortly after Grissom's attack appeared, the U. S. Congress enacted a bill which led to a reversal of the court-martial decision, clearing Hammond of all charges and restoring him to the rank of Brigadier General, retired.)

The famous ten-week trial in 1881-1882 of Charles J. Guiteau, assassin of President James A. Garfield, was another focal point of feud between institutional psychiatrists, extramural practitioners, and social workers. The *American Journal of Insanity*, during the trial and its aftermath, served as a major forum for those who believed Guiteau was sane. John P. Gray, its editor, was a chief witness for the prosecution at the trial. The *Journal of Nervous and Mental Disease*, on the other hand, championed the side which held Guiteau to be completely insane. Dr. E. C. Spitzka, an expert witness for the defense at the trial, represented the view of most prominent neurologists, that Guiteau was an irresponsible madman. Hammond, in this instance, occupied a middle ground, expressing the belief that Guiteau was insane but should be put to death as a deterrent measure against the possibility of future presidential assassinations.²⁹ The Association for the Protection of the Insane and the Prevention of Insanity actively aided the forces seeking to save Guiteau from execution

²⁸ *Am J Insanity*, XXXV (1878), 1-36.

and circulated several petitions pleading for his life as an irresponsible lunatic.²⁸

Meanwhile, the Association directed its main efforts toward mobilizing public opinion in favor of "asylum reform." It strove principally for the abolition of mechanical restraints, stricter safeguards against illegal commitment and detention, more "liberty" for patients, control of the "despotism" of superintendents, creation of central lunacy boards, and more active scientific research among institutional psychiatrists. In 1882 the Association adopted a resolution urging a sweeping, nationwide investigation of insane asylums by the U. S. Congress. No action resulted from this resolution.

One important activity of the Association for the Protection of the Insane was its vigorous advancement of psychiatric instruction in general medical colleges. Formal psychiatric education was negligible at the time. After the death of Benjamin Rush in 1813, it appears that no systematic course in psychiatry was given anywhere in the United States up to 1867, when William A. Hammond was appointed professor of nervous and mental diseases at the Bellevue Hospital Medical School in New York. A year later Edward C. Seguin received a lectureship in mental diseases at the College of Physicians and Surgeons, also in New York. Dr. Isaac Ray conducted summer courses in psychiatry at the Jefferson Medical School in 1870-1872. About the same time, a department of nervous and mental diseases was established at the New York Homeopathic Medical School, with Dr. S. Lilienthal directing a full course of instruction.²⁹ In the 1870s, a few more courses in mental and nervous diseases were established at other institutions; they were conducted mostly by practitioners in the infant art of neurology. Such was the extent of psychiatric education up to the 1880s.

Symptomatic of the gross neglect of psychiatry in medical schools was the fact that Benjamin Rush's *Medical Inquiries and Observations upon the Diseases of the Mind*, first published in 1812, and John Galt's *The*

²⁷ For lengthy and interesting discussions on the Guiteau trial, from the viewpoint of medical jurisprudence, see the *American Journal of Insanity* and the *Journal of Nervous and Mental Disease* for 1881 and 1882, *passim*, see also the chapter in this volume, "Legal Aspects of Psychiatry."

²⁸ At the trial itself, eight experts testified that Guiteau was insane, fifteen that he was sane.

²⁹ T. H. Weisenberg, "Neurologic Teaching in America," *Transactions of the Section of Nervous and Mental Diseases of the Am Med Assn* (1908), 9-24; "Psychiatry in the Schools," *Am Psychological J*, I (1883), 171-172, see also the chapter in this volume, "American Psychiatry as a Specialty."

Treatment of Insanity, published in 1846, remained the only systematic psychiatric treatises in America until 1883, when two new texts finally appeared. Both of them, significantly, were the works of neurologists—William A. Hammond and Edward C. Spitzka.⁸⁰

At its annual meeting in 1882, the Association for the Protection of the Insane appointed a committee to draft a circular on psychiatric instruction to be sent to the faculty of every medical school in the country. The circular was duly prepared by a committee consisting of Drs. Seguin, Mary Putnam Jacobi, and Margaret A. Cleaves and was sent to every medical school. It read, in part:

Since the incipient stage of mental disease must always be passed under the observation of the general practitioner before the patient be definitely committed to the expert as insane, it is extremely important that a knowledge of such diseases be widely diffused throughout the profession.

Usually the diagnosis of insanity is incorrectly or imperfectly stated in medical certificates, and a rational attempt to treat the case at home is not made, because the physician shrinks from assuming a responsibility for which he has never been prepared . . .

Many cases of impending insanity are allowed to progress, when an adequate knowledge of the subject might have enabled the family physician to ward off the catastrophe.

A training in psychiatry would, in our opinion, enable the general practitioner to more successfully treat the mental symptoms exhibited by many patients not actually insane.

We believe that the time has come when, in this country, no course of medicine should be considered complete without attendance upon lectures and clinics on mental diseases; and that no student should be allowed to graduate without passing an examination in psychiatry.

With this preamble, the committee, in the Association's name, urged each medical school to introduce a thorough system of instruction by means of "1) A chair or lectureship in psychiatry; 2) A clinic of psychiatry, held in an asylum for the insane in your city or near it."⁸¹

Dr. Charles K. Mills, in an address before the Association for the Protection of the Insane at its 1883 meeting, made this special plea to the general practitioner to avail himself of psychiatric instruction, in the in-

⁸⁰ Hammond, *A Treatise on Insanity in Its Medical Relations* (New York, Appleton, 1883); Spitzka, *Insanity Its Classification, Diagnosis, and Treatment* (New York, Bermingham, 1883); see also the chapter in this volume, "American Psychiatric Literature during the Past One Hundred Years."

⁸¹ Charles K. Mills, "The Duty of Medical Colleges and the General Practitioner toward Mental Diseases," *Am Psychol. J.*, I (1883), 79-80; *Ibid.*, p. 93.

terest of mental hygiene: "It is his duty to give attention to mental diseases, that he may be able to enlighten and direct his patient and the community at large with reference to the best means of preventing insanity. The great subject of mental hygiene should find in him an exponent and an advocate."⁸²

In 1883 the Association felt sufficiently secure to establish its own organ, the *American Psychological Journal*, which was launched as a quarterly in April of that year. The bulk of the *Journal* was devoted to the crusade for asylum reform, largely in the form of papers and proceedings of the meetings held by the Association which it served as organ. Occasionally there also appeared papers on the prevention of insanity, which would today come under the heading of mental hygiene.

The editor was Dr. Joseph Parrish of Burlington, New Jersey, who had a particular interest in the problem of alcoholism. In consequence, the subject of inebriety, in its relation to the preventive and curative aspects of mental disease, occupied an inordinate space in the *Journal* throughout its brief existence. •

The *Journal* never reached a wide circulation, and from the start seems to have been bedeviled with financial problems. After striving manfully to keep afloat, it sank into oblivion with its issue of October, 1884, ending a life of eighteen months.

The Association for the Protection of the Insane did not long survive its literary organ. It appears to have been wrecked on the rocks of internal dissension, after a most promising start. Scientific men like Spitzka withdrew their initial support because of dissatisfaction with the Association's tendency to stress humanitarian rather than scientific factors in the care and treatment of mental ills. Some of the younger institutional psychiatrists who had joined the movement soon left it, partly because of undisguised pressure from colleagues by whom they were regarded very much as traitors and heretics, and partly because of disapproval of the Association's sensationalistic and sometimes unfair attacks on asylums. The Association suffered considerably, too, in the early loss of two of its prime movers, Drs. George M. Beard and Hervey B. Wilbur, both of whom died in 1883.

I have not been able to trace the exact date of the demise of the NAPIPI. It faded speedily from the public eye after 1884, although it appears to have been at least nominally, if but feebly, alive as late as 1886.

⁸² *Ibid*, p. 78.



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Summing up the final accounts of the society, one would be likely to find much good achieved, and some ill. The NAPIPI bore responsibility, in varying degrees, for certain negative or retrogressive results.

1. Its propaganda on asylum abuses placed too much stress on "bad" institutional superintendents, too little on genuine evils beyond the control of individual asylum heads. Thus, public opinion was deflected from due consideration of the important issues in asylum reform.

2. It overplayed the part of its program dealing with humanitarian reforms in institutions; conversely, it never gave adequate emphasis to the mental hygiene, or preventive, aspects of the program.

3. It correctly exposed gaping loopholes in existing laws governing the commitment and detention of persons adjudged insane, but the reforms it proposed for protection of "the rights of the insane" were sometimes worse than the existing evil. Occasionally, agitation started by it got out of hand, and in some states led to passage of iniquitous laws requiring jury trials for persons "accused" of insanity.

An example of the eerie legislative action brought about by the "rights of the insane" agitation of the National Association and other groups was a bill introduced into the New York State Legislature in 1882. The bill passed the State Assembly by an overwhelming majority but failed to reach the Senate in time for a vote. It provided that no person could be admitted to an asylum as insane except by a court order after "trial" of the "accused" and a verdict of insanity by a jury of twelve men; that "such trial shall be conducted in all respects as a trial for a felony," with right to call witnesses, challenge jurors, and so on. Persons detained in a mental hospital for more than one year could, on demand, have a trial by jury.⁸⁸

The positive accomplishments of the NAPIPI, however, seem to have far outweighed the negative results of its activities.

1. It focused public attention on all-too-real abuses in mental hospitals, exposing instances of cruelty and neglect of patients, together with excessive use of mechanical restraints such as straitjackets, cribs, handcuffs, and chains. It also helped educate the public in general problems of the care and treatment of mental disease.

2. Attacks by the society infuriated many mental hospital superintendents but also had the effect of putting them on their mettle. They

⁸⁸ John B. Chapin, "Public Complaints against Asylums for the Insane, and the Commitment of the Insane," *Am J Insanity*, XL (1883), 47

were shaken out of the complacency of isolated routine, and were goaded into introducing more research work into their institutions.

3. The sharp criticism leveled by the society at the Association of Medical Superintendents as a "closed corporation" undoubtedly accelerated the process of opening up the superintendents' organization to assistant physicians. In 1885, at a meeting presided over by the aged Pliny Earle, the Association of Medical Superintendents finally opened the doors of membership to persons with at least five years' continuous service as medical officers of mental hospitals. In 1892 a still more radical step was taken when the organization changed its name to the American Medico-Psychological Association, signifying the new stress on the study and treatment of mental disease, and a change in the purely institutional character of the society.

The turn of the present century was a propitious time for the launching of health and humanitarian movements. There were great stirrings in the worlds of medicine and social welfare. The revolutionary progress in preventive medicine during the few brief decades following Pasteur's formulation of the germ theory of disease had created a wave of tremendous optimism. As dread scourges were one after another brought under control in the western world, unlimited horizons seemed to open up in the field of preventive medicine. If one disease could be conquered through the sudden and dramatic discovery of its cause, why not another? Why not all, including that most baffling of all human ailments, mental disease? In hundreds of laboratories, scientists were busy probing into the secrets of the human brain in patient efforts to pry from its convolutions and complex organization the key to mental and nervous disorders.

The period was, at the same time, the golden age of social reform. Young men burning with the desire for a better America were traveling through the length and breadth of the land, exposing to the light of day the evils and abuses, the injustices and inhumanities, that characterized many American institutions. They were called "the muckrakers," and they included such crusading reporters as Upton Sinclair, Ray Stannard Baker, Lincoln Steffens, and Ida Tarbell.

There were movements for abolishing the slums, for decent housing for the poor, against the evils of child labor and unsanitary factory conditions, for improved wages and hours for working people, against political corruption in municipal government, for better protection of infant

and maternal health, for the fuller utilization of known public health principles to build a sturdier, happier nation. More significant is the fact that, more and more, these trends found *organized* expression.

It was in this favored climate that the mental hygiene movement was founded. It all started with a man and a book. The man was Clifford Whittingham Beers, a native of New Haven, Connecticut. The book was his autobiography, *A Mind That Found Itself*. Beers spent four uneventful years at Yale, graduating in 1897, and then started on a conventional business career. In 1900 he suffered a "nervous breakdown," climaxed by an attempt at suicide. He spent the next three years in three different mental hospitals, private and public. In all he was subjected to gross brutalities—corporal punishment, restraint in straitjackets, solitary confinement, countless humiliations at the hands of inhuman attendants and indifferent medical officers. He observed many of his fellow patients being subjected to similar treatment. Incensed by these cruelties and indignities, Beers addressed long letters of protest to President Theodore Roosevelt, the governor of Connecticut, and sundry other officials, demanding sweeping investigations of the mental hospital system.

His many complaints having failed to evoke satisfactory official action, Beers, possessed of an amazingly stubborn and aggressive nature, decided to do something himself. In the latter part of his stay in mental hospitals, he passed out of a long period of profound depression into one of extreme elation. During this state of elation he conceived a grandiose plan to form a world-wide movement for the reform of such asylum abuses as he and his fellow patients had experienced and which, he had reason to believe, were rampant in other institutions. To familiarize himself with every aspect of asylum life, Beers several times deliberately provoked his attendants to throw him into the "violent wards," where he witnessed indescribable horrors.

Toward the end of his three-year period as a patient in a mental hospital, Beers started to write down his observations. He wrote at a furious rate; his pen could scarcely keep up with his excited thoughts. Ordinary writing paper could not contain the flood of his impassioned reflections on asylum abuses. He had large rolls of wrapping paper brought to his room, and he filled roll after roll with his writings.

He did not forget his self-imposed mission to improve the conditions of the mentally sick when he emerged from his third mental hospital in 1903. The idea burned within him more fiercely than ever. So excited

did he become, in fact, that he returned to the hospital as a voluntary patient for a short period. This time he emerged recovered.

Beers now went about his plan for a reform movement, first conceived within the walls of a mental hospital, with the cool calculation of a master strategist. He returned to the business world for a brief period, working out his plan in his spare moments. But on this part-time basis things did not proceed fast enough for the strong-willed, impetuous young man in whose memory were etched the vivid scenes of institutional cruelty. So Beers gave up his job in order to devote himself unreservedly to his reform crusade. He was deeply impressed with the prominent role a book—*Uncle Tom's Cabin*—had played in the antislavery movement. Why not a similar book, a recital of his own experiences, to serve as the springboard for the movement in behalf of that unfortunate class to which he had lately belonged? He gathered the voluminous notes composed at fever heat in a mental hospital. He tempered them with just the right proportion of objectivity, sharpened them with masterly touches of irony, added and deleted, wrote and rewrote, submitted drafts of the manuscript to eminent psychiatrists and literary men for criticism.

The result was that classic autobiography, *A Mind That Found Itself*, published in 1908. It was unique in American literature, a book that started a great movement. It was distinctly different from the many autobiographical "asylum exposés" that had previously appeared. It was no mere recital of personal suffering. It not only exposed existing evils, but proposed wise remedies. Its author declared:

A permanent agency for reform and education in the field of nervous and mental diseases is one of the great needs of the day. Such an agency—whatever its form—could do in its own field what the National Society for the Prevention and Cure of Tuberculosis has done, and is doing, in its sphere of activity. Though the improvement of conditions among those actually insane and confined should ever be an important factor in shaping the policy of such an organization, its most important work would be the waging of an educative war against the prevailing ignorance regarding insanity. This, to cure the disease by preventing it, is the only effective cure known. The watchword of such an organization might well be the significant phrase: Mental Hygiene. . . .

Having promised the reader a "remedy," I dare to offer a definite recommendation, based on the advice of interested supporters who, for years, have been actively engaged in successful works of reform and education. I suggest that a "National Gommittee" (modeled after the very efficient "National Child Labor Committee") shall, without delay, be brought to a working perfection . . .

Suffice it to say that the "National Committee for Mental Hygiene" (I present the name for consideration) would be equally the friend of the physician and the patient, also the friend of a patient's relatives, to whom, when burdened with an actual or impending affliction, it would become an unfailing source of information, advice, and comfort. In a word, it would be a friend to Humanity, for no man knows when he himself may have to look to it for assistance.⁸⁴

The book was an instantaneous success. It stirred reviewers in the professional and popular press to expressions of deep approval. It was widely circulated, and widely quoted. The country showed itself ready for just such an organized movement as Beers had proposed.

Even before his book was published, Beers had laid the groundwork for a national committee. He had sought out leading psychiatrists, neurologists, social workers, and social-minded laymen, and had received gratifying responses. It was Dr. Adolf Meyer, then director of the New York State Psychiatric Institute, who suggested to Beers the phrase "mental hygiene" as the key term of the movement.

Beers was ready to launch the nation-wide movement as soon as his book appeared. But sage advisers counseled him to begin on a more modest basis, within his home state. Thus the Connecticut Society for Mental Hygiene was founded in New Haven in May, 1908, closely following the publication of *A Mind That Found Itself*. Beers was made executive secretary of the society.

The state-wide experiment soon proved impressively successful. February 19, 1909, a red-letter day for the movement, marked the founding in New York City of the National Committee for Mental Hygiene. The twelve charter members present at that historic meeting represented a cross-section of leaders in psychiatry and neurology, philosophy, social work, religion, and philanthropy. They were: Lewellys F. Barker, Russell H. Chittendon, Horace Fletcher, August Hoch, William James, Julia Lathrop, Marcus M. Marks, Adolf Meyer, Frederick Peterson, Jacob Gould Schurman, the Rev. Anson Phelps Stokes, Jr., and Clifford Beers himself. Beers was appointed secretary, a position he held for three decades. A serious illness forced him to retire from active leadership in 1939. He died in Providence, in July, 1943.

The chief aims of the National Committee, as outlined in an early prospectus, included the following:

⁸⁴ Clifford W. Beers, *A Mind That Found Itself* (New York, Longmans, Green, 1908), pp. 295-296

To work for the protection of the mental health of the public;

To help raise the standard of care for those in danger of developing mental disorder or actually insane;

To promote the study of mental disorders in all their forms and relations and to disseminate knowledge concerning their causes, treatment, and prevention;

To obtain from every source reliable data regarding conditions and methods of dealing with mental disorders,

To enlist the aid of the Federal Government so far as may seem desirable;

To coordinate existing agencies and help organize in each State in the Union an allied, but independent, Society for Mental Hygiene, similar to the Connecticut Society.³⁵

Here was an ambitious program. In essence, it differed but little from that of the abortive National Association for the Protection of the Insane and the Prevention of Insanity. But in detail it was clearer, firmer, bolder. The happy choice of "mental hygiene" as the key term of the movement infused it with optimism and breadth. (Beers, by the way, did not learn of the earlier existence of the Association for the Protection of the Insane until some time after he had launched the mental hygiene movement.)

The movement was launched at an auspicious moment. There was a need for it and, more important, there was a growing awareness of the need. Its sponsorship was certain to impress. On the negative side, the great backlog of skepticism, defeatism, and confusion that had grown around the subject of mental disease through the centuries had to be overcome. The wide acceptance of the despairing motto, "Once insane, always insane," had inevitably built up a wall of apathy against progressive measures in behalf of the mentally ill.

No sensational events marked the first three years of the National Committee for Mental Hygiene. Organization proceeded slowly and carefully. The enthusiasm for the movement did not readily translate itself into terms of adequate financial assistance. Indeed, at one point the continuance of the society was made possible only by a timely \$1,000 loan from William James to Clifford Beers.

Two events in 1912 combined to give a great lift to the work of the National Committee. One was a gift of \$50,000 from the railroad mag-

³⁵ *Origin, Objects and Plans of the National Committee for Mental Hygiene* (New York, National Committee for Mental Hygiene, 1912), p. 2

nate, Henry Phipps—who also financed the establishment of the Henry Phipps Psychiatric Clinic in Baltimore. This large donation put the Committee on a working basis for the first time.

The second notable event of 1912 was the engagement of Dr. Thomas W. Salmon as director of a series of mental hygiene studies projected on a state-by-state basis. Salmon, then a thirty-six-year-old psychiatrist, had been connected with the U. S. Public Health Service, handling problems of mental disorder among newly-arrived immigrants on Ellis Island. Several of his published reports on insanity and immigration, which reflected an independent and fresh approach to the problem, had attracted wide and favorable attention. In 1915 Salmon was made medical director of the National Committee, a post he held until his resignation in 1921.

The coming of Dr. Salmon to the National Committee proved a great stroke of luck. He possessed, according to those who worked with him, a rare combination of virtues. He had a winning personality, an imagination capable of conceiving large-scale projects, and a keen intelligence and administrative ability capable of carrying them through. He gave to the Committee a professional leadership that perfectly complemented the lay leadership of the founder, Beers, whose early crusading zeal was harnessed to a shrewd talent as a money-getter for the organization.

The first important project of the National Committee was a study of the existing mental hygiene facilities in the United States, with the idea of obtaining an over-all picture as a foundation for constructive work. The project resulted in the completion of sixty state-wide and local surveys. The surveys centered mainly on institutional care for the mentally handicapped, and led to distinct improvements in many states.

World War I presented a great challenge and a great opportunity; thanks largely to the outstanding medical statesmanship of Salmon and the organizing ability of Beers, the movement was prepared to meet both. The story of psychiatry and mental hygiene in the first World War is told elsewhere in this volume.⁸⁰

Suffice it to say here that the task of organizing a psychiatric branch in the Army Medical Corps was entrusted to the National Committee for Mental Hygiene by the Surgeon General's Office. Dr. Pearce Bailey was appointed chief of the psychiatric division. Dr. Salmon became chief of psychiatry in the American Expeditionary Forces. In this capacity he helped build up an efficient system of hospital treatment for psychiatric

⁸⁰ See the chapter, "Military Psychiatry."

casualties in the A.E.F. He also helped plan and put into effect psychiatric screening processes for draft registrants, and positive morale work among soldiers. Finally, he tried hard, but with only partial success, to set up a sound system of rehabilitating returning soldiers afflicted with mental disorders.

World War I gave a great impetus to the mental hygiene movement. It dramatized the need for a positive program of mental health. Wartime tensions brought to the surface many of the problems of mental disease that had remained hidden or underestimated in peacetime. The War also focused attention on the relationship between psychiatry and various fields dealing with matters of social maladjustment.

In no other field was the impact of the mental hygiene movement felt as strongly as in social work. Factors operating during and after World War I brought to a climax the trend toward convergence of mental hygiene and social work that had been in motion for many decades.

Social workers had long been in intimate touch with the problems of mental disease. In fact, the care and treatment of the insane had been the concern mainly of poor-law officials—when the mentally sick were mostly confined in poorhouses and prisons—long before it was recognized as primarily a medical problem to be treated in special hospitals. Social workers also had to deal with families rendered indigent when breadwinners fell victim to mental disease.

At the turn of the century, psychiatrists became increasingly aware of the value of obtaining social histories of their patients. In 1905 mental hospitals started to employ trained social workers to obtain such histories and to do follow-up work on discharged patients in their homes. The introduction in America of the aftercare movement, about the same time, also brought social work closer to matters affecting the mentally ill. Its main purpose was to help the paroled or discharged patient to readjust himself successfully to community life.

The founding of the mental hygiene movement by Clifford Beers greatly accelerated the trend toward convergence of mental hygiene and social work. Social workers were prominently identified with the movement from the start. A leading social worker, Julia Lathrop, was one of the twelve charter members of the National Committee for Mental Hygiene.

As psychiatry increasingly recognized the role of environmental factors in the causes, prevention, treatment, and ultimate cure of mental

disease, they tended more and more to call in social workers to collaborate with them. This stimulated the rise of psychiatric social work as a profession. Meanwhile, social workers were placing increasing stress on personality factors in the problems of dependency, delinquency, and family breakdown with which they dealt. In 1917, Mary E. Richmond defined social case work as consisting "of those processes which developed personality through adjustments consciously effected, individual by individual, between men and their social environment."

The close collaboration between psychiatry and social work during this period was symbolized by the pioneer cooperative efforts of Dr. Elmer E. Southard and the social worker, Miss Mary C. Jarrett, at the Boston Psychopathic Hospital. The concept of psychiatric social work was first enunciated in their book, *The Kingdom of Evils* (1922).

As has been mentioned, World War I imposed the problem of rehabilitating returning psychiatric casualties, and social workers were called upon to play a leading role in this work. The problem dramatized, as few other problems had, the need for integrating psychiatric techniques with social work.

Discussion of mental hygiene dominated the National Conference of Social Work held at Atlantic City in 1919. Enthusiasm for mental hygiene swept the social work field. The next decade witnessed such an intense interest that to many the terms "social work" and "mental hygiene" became well-nigh interchangeable.⁸⁷

The postwar years also saw rapid advances in the application of mental hygiene to the study and treatment of child-behavior problems. The child guidance movement, led by such psychiatrists as William Healy, Augusta Bronner, George S. Stevenson, Lawson G. Lowrey, and David M. Levy, had its formal beginning in 1922. Mental hygiene clinics were established in connection with children's courts and in institutions for juvenile and adult delinquents.

Another tangible product of the movement was the accelerated trend toward organizing mental hygiene clinics in the community. Most of them were connected with mental hospitals, some were attached to outpatient departments of general hospitals or to social agencies, courts, and correctional institutions; some were independently created.

Still another area invaded by mental hygiene in the postwar years was

⁸⁷ Albert Deutsch, "The Convergence of Social Work and Psychiatry: an Historical Note," *Mental Hygiene*, XXIV (1940), 92-97.

the field of personnel relations in industry. Dr. Elmer E. Southard was a pioneer in this movement. Southard and others insisted that psychiatrists—or teams of psychiatrists, psychologists, and social workers—could prove invaluable in selecting personnel scientifically. They could also help to solve the emotional problems of individual workers as well as general problems of personnel relations, to the mutual benefit of employee and employer.

After an impressive start, the movement to harness psychiatry to industry bogged down, mainly as a result of lack of confidence on the part of both employers and employees. Employers tended to suspect psychiatrists as crackpot theorists, workers suspected them as potential stooges for management who could help get rid of union organizers as “emotionally unbalanced trouble-makers.” Recent years have seen a vigorous revival of efforts to introduce mental hygiene principles in the selection and morale of industrial personnel.

The 1920s witnessed a tremendous rise of popular interest. In fact, the movement was grossly oversold by overenthusiastic converts who advanced mental hygiene as a sure cure for practically every ill that beset the world, political, economic, social, and individual. Sober leaders felt constrained to issue repeated warnings against overoptimism that could only harm the movement in the end. Meanwhile the spread of societies had proceeded steadily, here and abroad. *Mental Hygiene*, an official quarterly organ for the movement, was founded in 1917. Its original editor, Dr. Frankwood E. Williams, succeeded Salmon as medical director of the National Committee in 1921. By 1943 some seventy-eight local and state mental hygiene societies had been organized in thirty-two states. Thirty countries, covering every continent on the globe, had their own organizations.

A milestone in the development of the movement was reached in 1930, when the first International Congress on Mental Hygiene was held at Washington, D. C. Three thousand persons attended, representing fifty nations besides the United States. The following points were included among the major aims of the Congress:

1. To bring together from all countries . . . workers in mental hygiene and related fields, for exchange of information and experience, and for mutual consideration of individual and social problems growing out of nervous and mental disease, mental defect, and mental and emotional maladjustments of the individual in his personal and social environment.

2. To consider ways and means of world coöperation and of more effective promotion of mental hygiene in the various countries.³⁸

The International Congress climaxed the uphill fight of Clifford Beers to realize his "crazy" dream. An International Committee for Mental Hygiene was organized at this Congress of 1930. The second International Congress on Mental Hygiene was held at Paris in 1937, with René Charpentier presiding and Clifford Beers serving as honorary secretary.

Two major emergencies have arisen in recent years to challenge the utility of mental hygiene as an instrument for treating emotional problems in the mass. The first was the Great Depression, which started in 1929 and lasted a decade. At first the mental hygiene approach to the economic crisis was presented in such trite and bromidic formulas as "Keep smiling," "A man may be down but he's never out," "Keep your chin up," and "Every cloud has a silver lining." More mature and considered efforts followed.

Mental hygienists, however, became convinced in time that the basic causes of the depression were economic and not emotional, and that the basic cures must therefore be sought in the economic rather than the psychiatric sphere. But they were able to provide social agencies with many valuable hints on handling the personal and family problems of the unemployed.

The second great emergency challenging mental hygiene in recent years is, of course, World War II. This war has presented mental hygiene with its greatest opportunity for service. Its main field of utility may be defined as follows:

1. Maintenance and strengthening of morale on the home front.
2. Formulation of techniques for selecting military recruits for the armed forces.
3. Building up of military morale.
4. Rehabilitation of rejected draft registrants and of military men returned to civil life as psychiatric casualties of war.
5. Maintenance of adequate standards in mental hospitals.

It must be said, in all candor, that psychiatry and mental hygiene were slow to accept the challenge presented to them by the war emergency. This unpreparedness was, in some respects, inevitable. The psychiatric

³⁸ Frankwood E. Williams, ed., *Proceedings of the First International Congress on Mental Hygiene* (New York, The International Committee for Mental Hygiene, 1932), I, 9-10

profession was far too small in number to meet adequately the heavy demands made upon it. Selective service, military and civil officials were in large measure indifferent, and even hostile, to the idea of calling psychiatry and mental hygiene to their aid. The profound lessons of World War I regarding the significance of mental hygiene in wartime were for the most part forgotten. The National Committee for Mental Hygiene, which in 1917 was promptly called upon to provide leadership for the organization of psychiatric services in the armed forces, was ignored by the responsible authorities at the commencement of the present emergency. Lack of adequate funds hampered efforts by the National Committee to bring before the public the urgency of applying sound mental hygiene principles in definite areas where they were of value. A certain amount of indecision and hesitation on the part of leaders in psychiatry was also a factor in delaying proper official recognition of the role of mental hygiene in wartime.

History is now repeating itself. The consequences of ignoring psychiatric aids have become manifest to authorities who at first were content to ignore them. Mental hygiene, as a morale factor in civilian and military life, is receiving gradual and belated public recognition. At this writing, it appears that the movement will be given even greater impetus, in terms of permanent effects, than it received from World War I. But the road ahead is still beset with grave difficulties. From the very start there has been a chronic lack of adequate finances. While many superstitions and misconceptions about mental disease have been cleared up, the whole subject still remains a virtual *terra incognita* to the vast majority of Americans and, unfortunately, even to many general practitioners in medicine.

A natural obstacle to the growth of the movement is the fact that there is relatively little actual scientific knowledge concerning prevention. Until there is considerably greater body of scientific data on preventive measures, this aspect of the mental hygiene movement cannot advance very far. Another hurdle is created by the great gulfs and conflicts existing between the several schools of psychiatric theory. Organizations have often been hamstrung by the failure of various elements in their structure to agree on general principles of approach and public education. When these handicaps are eased, the road will be cleared for gigantic strides forward.

ALBERT DEUTSCH

I. MILITARY PSYCHIATRY: THE CIVIL WAR, 1861-1865

PERHAPS the outstanding medical event of the Civil War was the rise of the neurological profession in America. The Civil War is often regarded as parent, or at least nurse, to that infant profession. The four years of fratricidal strife also produced data on military psychiatry that might have proved valuable in future wars had their lessons not been so soon forgotten, only to be painfully relearned. Most interesting, perhaps, were the clinical observations of medical officers on such subjects as nostalgia and malingering among soldiers, together with notes on psychiatric screening in selective service.

Dr. William A. Hammond, Surgeon General of the U. S. Army from 1862 to 1864, and later a leading neurologist, was chiefly responsible for opening the way to the remarkable progress in neurology resulting from the Civil War. His meteoric rise and fall as Surgeon General marks one of the most dramatic episodes in the history of military medicine in America.

Hammond was appointed Surgeon General of the U. S. Army on April 25, 1862, when he was only thirty-four years old. He had served as an army doctor for eleven years after getting his medical degree, had resigned his commission, and was professor of physiology and anatomy when the firing of Fort Sumter in April, 1861, signaled the start of the Civil War. He immediately enlisted in the Union Army as an assistant surgeon with the rank of first lieutenant, a rank lower than the one he had previously held. His skill as a hospital inspector and administrator, and his vigorous efforts to eliminate flaws in the creaky Army medical organization, came to the attention of the U. S. Sanitary Commission, whose members were duly impressed.

The Sanitary Commission was at the time urging that the incumbent in the office of Surgeon General, an elderly routineer apparently unable to cope with the vast needs of the war emergency, be replaced by a younger, more vigorous man with broader vision. The Commission also proposed the complete reorganization of the Army Medical Department. It looked favorably upon young Hammond as the man to accomplish this task and, overcoming violent opposition, persuaded President Lincoln to appoint him Surgeon General.

As Dr. Charles J. Stillé observes in his history of the Sanitary Commission.

No one probably ever succeeded to a more arduous and embarrassing position. A young man, taken from near the foot of the list, and promoted over the heads of those who numbered almost as many years of service as he did of life, could not expect to find many warm friends or cordial supporters among his former official superiors. This natural result was aggravated by personal controversies which had arisen among the different candidates and their supporters during the canvass for the office.¹

Undaunted by the difficulties of reorganizing the Army Medical Department in the midst of war and in the face of stubborn opposition all about him, young Hammond plunged into the task of whipping up an efficient military medical service. A man of vision, he founded the famous Army Medical Museum and recommended the establishment of an Army Medical School and a Surgeon General's library. Both proposals were later adopted.

Surgeon General Hammond was an extraordinarily strong-willed person, a man of dominant personality. This characteristic was at once his strength and the cause of his undoing in military life. It brought him into immediate and sharp conflict with the autocratic Secretary of War, Edwin M. Stanton, who developed a strong dislike for him. It aroused hostility among many of his medical colleagues. His occasional extremism—as when he once prohibited the use of calomel for any purpose whatever upon learning that it was being administered too liberally by some Army doctors—was utilized by his enemies to discredit him.

In 1864 Hammond was court-martialed on charges of irregularities in connection with contracts for medical supplies. The Surgeon General, in a famous rebuttal defending his administration and character, charged that he was the victim of a frame-up engineered by his enemies. The U. S. Sanitary Commission addressed a communication to President Lincoln declaring its faith in Hammond. Nevertheless, he was found guilty and dismissed from the Army in disgrace. This blow might easily have crushed a less sturdy character. But Hammond stood firm, never ceasing his struggle for vindication. He went to New York City, started private practice as a neurologist, and quickly rose to leadership in that profession. He edited several of the pioneer neurological journals. Like his

¹ Charles J. Stillé, *The History of the United States Sanitary Commission* (Philadelphia, Lippincott, 1866), p. 134.

friend, S. Weir Mitchell, he was a man of literary ability. Besides a prolific outpouring of medical papers and books, his writings include a number of successful novels and plays.

Hammond was one of the pioneer professors of nervous and mental diseases and helped found the New York Post-Graduate School of Medicine. In 1871 he published his *Treatise on Diseases of the Nervous System*, advertised as the first textbook of its kind in the English language. Twelve years later he published *A Treatise on Insanity in Its Medical Relations*.²

In 1879 Congress enacted a bill authorizing a review of the court-martial proceedings which had led to Hammond's conviction. This review vindicated Hammond fully. As a result, he was restored with honor to the Army rolls, on the retired list with the rank of brigadier-general.³

One of Hammond's most lasting achievements as Surgeon General was his role in developing American neurology, and in giving such men as S. Weir Mitchell and W. W. Keen an opportunity which turned them permanently to work in neurology.

In his autobiographical account, Dr. Mitchell tells how this happened. Describing his career as a surgeon in the Union Army, he says:

My years in the U. S. Hospitals were confined, except for a few days' work away from home, to the great hospitals surrounding Philadelphia, where in fact there were 26,000 beds for the sick and wounded. . . .

My first appointment, in October, 1862, was at the Filbert Street Hospital, of which I have given some account in my first novel, *In War Time*. There I began to be interested in cases of nerve disease and wounds of nerves, about which little was then known. In consequence, other men who did not like these cases began to arrange transfers to my ward.

This so interested the Surgeon General that he created a small hospital for nerve diseases in Christian Street,⁴ in what was known as the Commissioners' Hall in the old district of Southwark. Dr. George R. Morehouse was

² New York, Appleton, 1883

³ William A. Hammond, *A Statement of the Causes Which Led to the Dismissal* (New York, 1864), *Record of a Memorial Meeting in Honor of the Late Surgeon General William A. Hammond, Held at the New York Post-Graduate Medical School and Hospital, May, 1900*; U. S. Sanitary Commission, *Documents*, 1863-66, No. 75

⁴ The Surgeon General's order establishing this special hospital was dated May 23, 1863, and reads "The Surgeon-General directs that a ward be set apart in either the South or Christian St. Hospital for the exclusive treatment of diseases of the nervous system, and that contracts be made with Drs. S. W. Mitchell and Morehouse, and that they be assigned to the charge thereof." Dr. W. W. Keen was later assigned to duty with Mitchell and Morehouse. *Medical and Surgical History of the War of the Rebellion, 1861-65* (Washington, Government Printing Office, 1870-1888) II, 725.

associated with me in this work. The hospital again outgrew the building, and again the Surgeon General created a new special hospital of 400 beds, in an old country seat on Turner's Lane near Nineteenth. Surgeon Alden was in charge. Dr. Morehouse went with me and I asked to have Dr. W. W. Keen as assistant surgeon, a man whose distinguished career all men know and with whom I have preserved constant friendship. Dr. Da Costa had a ward, which afforded him a chance for a classical study of exhausted hearts and for other able papers, but with that exception the place was for patients with nerve disorders or wounds of nerves. There came out of this a series of well-known papers and one book which revolutionized knowledge as to wounds of the nerves. . . .

The cases were of amazing interest. Here at the time were 80 epileptics and every kind of nerve wound, palsies, choreas, stump disorders. . . .

Thousands of pages of notes were taken. . . . About midway we planned the ultimate essays which were to record our work. . . . In this hospital massage was first used to restore action to limbs⁵ in which healing nerve wounds left the muscles palsied or for the rigidity of splinted cases. Here atropine was first employed hypodermically for muscular spasms. Our studies. . . are now a part of common medical knowledge but then were brilliantly fresh.⁶

The book referred to by Mitchell was his classic work, *Injuries of Nerves, and Their Consequences*,⁷ based mainly on cases studied at the Turner's Lane Hospital. Dr. Mitchell, who never suffered from a tendency to underestimate his own works, provides us with this evaluation of his book:

This volume, into which were gathered our war cases and many more, has remained the great storehouse of facts from which other books have drawn largely. In it are the earliest distinct accounts of ascending neuritis and the first recommendations as to the use of splint-rest and cold in neuritis, etc. The study of the psychical and other phenomena of the amputated here recorded has received no additions, and remains the sole authority.

Elsewhere, Dr. Mitchell tells us that his famous "rest cure" for mental and nervous disorders was first developed in his Civil War hospital work.⁸

The first of several important papers emanating directly from the Turner's Lane Hospital and signed jointly by Mitchell, Morehouse, and Keen, was a pioneer work entitled *Reflex Paralysis*, describing cases of

⁵ Anna R. Burr, *Weir Mitchell, His Life and Letters* (New York, Duffield, 1929), pp. 104-107.

⁶ Philadelphia, Lippincott, 1872.

⁷ *A Catalogue of the Scientific and Literary Work of S. Weir Mitchell, Annotated by the Author* (Philadelphia, 1894), p. 39, S. Weir Mitchell, "The Evolution of the Rest Treatment," *J. of Nerv. and Mental Dis.*, June, 1904.

sudden palsy resulting from wounds in remote regions of the body. It was published as Circular No. 6 from the Surgeon General's Office.

The second important study was published under the title, *Gunshot Wounds and Other Injuries of the Nerves*. This book⁸ added a great deal to the extant knowledge of its subject.

A third study was a rather extensive survey of malingering among Union soldiers, an important military problem from the psychiatric viewpoint. The authors pointed out that few cases of disease or disability among Union soldiers were self-induced as an escape from military duty.

The great majority of malingerers [they observed] consists rather of men who exaggerate real maladies of trifling character, or who feign disease outright. Of the two classes, the first is the larger. The real depletion of our ranks is not so much by feigned epilepsies, paralyses and the like—we speak now of our own experience—as by those cases of disease, once severe, or always slight by which men add invented symptoms, or continue to assert the existence of those which have passed away.⁹

Mitchell and his associates laid particular stress on a peculiar connection between malingering and the bounty system that was a feature of military recruitment at the time. The U. S. Government, in order to stimulate enlistment, had established the policy of paying bounties to volunteers. In 1863 this bounty amounted to \$300 to each enlisted man. States and localities eager to raise their allotted quotas of men often added their own bounties to that offered by the Federal Government. An unfortunate clause in the Draft Act of 1863—which created great popular resentment and culminated in the famous Draft Riots in New York City and elsewhere—allowed drafted men to avoid military duty by hiring other men as "substitutes" who went to war in their stead.

The bounty system, together with the clause allowing rich men to hire substitutes, resulted in many pernicious practices. A new profession of "bounty brokers" sprang up, centering around traffic in recruits, with the broker getting a percentage of the bounty price.¹⁰

A large number of recruits, it appears, turned this bounty system to personal account as a lucrative racket. Many with disqualifying ailments

⁸ By S. Weir Mitchell, George R. Morehouse, and W. W. Keen (Philadelphia, Lippincott, 1864).

⁹ "On Malingering, Especially in Regard to Simulation of Diseases of the Nervous System," *Am. J. of Med. Sci.*, XLVIII (1864), 367-394.

¹⁰ Fred A. Shannon, *Organization and Administration of the Union Army, 1861-65* (Cleveland, Clark, 1928), I, 49-99.

would conceal their symptoms at the induction centers. Once accepted, they would expose their symptoms, often with exaggerated emphasis, in order to obtain a discharge. Then they would repeat the same process of enlisting with a new bounty, and getting discharged. The selective service system was so loosely administered that it was easy for a discharged man to enlist under another name.

Besides the malingerers who sought outright discharge, there were others, especially among substitutes, who were content "if they could hoodwink the doctors far enough to secure for themselves the ease of hospital wards, and security from picket duty, and the bivouac."

The authors described at some length the different types of feigned diseases—epilepsy, lameness, blindness, backache, deafness, and mental disease. Cases of feigned insanity were uncommon, they said, since it was forbidden to discharge insane men from the Army, for reasons which will be described presently. "And any one who would feign insanity and submit to its restraints and associations to avoid work and obtain ease," the authors added, "must be in reality a monomaniac."

The authors also reviewed the standard methods of detecting malingerers. Besides giving pointers on the detection of specific diseases which might be feigned, they also advanced some observations on general methods of discovering malingerers. They declared that malingering was especially rife in general hospitals, where the men were separated from the medical officers who knew all about them. They advocated a system of espionage in military hospitals, whereby spies would be posted to watch cases of lameness, paralysis, and chorea, at times and places where the men would think themselves unobserved, "to see how they act when off their guard, to hear what they say when they are drunk."

How should malingerers be treated? Keen, Mitchell, and Morehouse discussed the following alternatives:

1. In deciding doubtful cases, the government rather than the men should be given the benefit of the doubt. The authors, however, stressed the need for caution, citing two cases where men suspected of malingering were exposed to barbaric cruelties, only to be proved really sick later.
2. "What should be done with cases of undoubted and obstinate malingerers; with men whose endurance and tenacity of purpose would be heroic, were the object in view a righteous one? Experienced army surgeons tell us that it is better, on the whole, to discharge such men. Under the old army rule this would, no doubt, be the best plan, for such men are, as a rule, useless as soldiers, and a dishonorable discharge brands the criminal with shame

and saves the government from expense. But under present circumstances, the man would merely change his residence, and re-enlist with a new bounty, to repeat again the same easy means of creating an income."

3. Another way to dispose of malingerers was to treat them harshly as a punishment and deterrent. For example, a "maligner's brigade" might be formed, with its members wearing a distinctive dress and given the dirtiest and hardest of police duties. "Men malinger in order to avoid work and obtain a discharge, and so long as one man succeeds in doing either, so long will ten others continue to imitate him. But if, thereby, they should only subject themselves to harder work than ever, add dishonor to hard labour, and lose all hope of a discharge, malingerers would be rarely seen." Here, too, the authors stressed the need for caution in determining whether the men in question were real malingerers before consigning them to disgrace and hard labor.

An interesting discussion on the problem of "teen-age induction," foreshadowing a debate over the same question in World War II, was set off by an isolated paragraph in Surgeon General Hammond's annual report for the fiscal year ending June 30, 1862. When the Civil War broke out, the minimum age for recruitment into the Union Army was set at twenty years. Subsequently, as the need for military manpower became acute, the minimum was reduced to eighteen years. Commenting on the psychiatric impact of this change, General Hammond declared:

In regard to the age at which recruits are received into service, a change is imperatively demanded, both for the interests of the Army and the welfare of individuals. The minimum is now fixed at 18 years, and it is not uncommon to find soldiers of 16 years old. Youths of this age are not developed, and are not fit to endure the fatigues and deprivations of the military life. They soon break down, become sick, and are thrown upon the hospitals. As a measure of economy, I recommend that the minimum age of recruits be fixed by law at 20 years.¹¹

No supporting evidence for this statement was presented in the Surgeon General's report. We have been unable to discover whether it was based on statistical data, empiric observation, or pure speculation. However, an article backing up Hammond's expressed view appeared in the *American Medical Times* of February 14, 1863. It was entitled, "The Evils of Youthful Enlistments, and Nostalgia," and came from the pen of Asst. Surgeon General DeWitt C. Peters.

The statistics and experience of the U. S. Army [wrote Peters] conclusively demonstrate that persons received at the minimum standard of 18 years are, in the majority of cases in this country, not sufficiently matured in mind

¹¹ Surgeon General, U. S. Army, *Report (Nov. 10, 1862) for Fiscal Year Ending June 30, 1862*.

and body to undertake successfully the arduous duties of a soldier. These young recruits readily contract the various diseases incident to camp life, and are extremely liable to prove a burden to the service, while prematurely their health is seriously undermined, if not ruined forever.

Peters severely condemned the loose methods of medical screening then prevailing, and urged a more stringent system of selective service to save manpower and money. He particularly criticized the practice of recruiting under-age boys in order to fill volunteer regiments with the requisite number of troops.

Dr. Peters explained the greater susceptibility of teen-age soldiers to mental disorders in this way:

The fresh and youthful American leaves his home imbued with patriotism, and animated by new associations. If he be from the rural districts, he is to all appearances the personification of perfect health. Stimulated by bright anticipations of the future, he may for a time resist the inroads of disease; but in a few months the novelty of long marches, guard duty, exposure and the innumerable hardships, has vanished. His mind begins to despond, and the youth is now a fair victim for fever or some other terrible scourge that is to wreck his constitution and blight his hopes.

In contrast with his case is that of his older and more sturdy companion. In him we see the man developed before quitting his peaceful pursuits. Both are tried by the same surrounding influences, yet the balanced mind of the latter acknowledges but few worldly disappointments, and his physical economy, by obeying the judicious laws of hygiene, soon adapts itself to the man's new mode of existence. The very young soldier, it has been remarked, wears better in the cavalry than in the infantry branch of the service, and in that sphere he may have a chance to cope successfully with his hardier comrades. It is perhaps the exciting and healthy life he thus leads, the attachment he quickly forms for his horse, and his ambition to excel, that buoy up his spirits and strength against contagion in its worst forms.

Peters, like Hammond, failed to reveal the statistical records or experience on which he based his judgment of the ability of teen-agers to adjust themselves emotionally to the rigors of war.

In the same article, Dr. Peters suggested that young men were more susceptible to nostalgia than older men. "It is by a lack of discipline, confidence and respect that many a young soldier has become discouraged, and made to feel the bitter pangs of home-sickness, which is usually the precursor of more serious ailments," he wrote. Peters approached the problem of nostalgia from a strongly psychosomatic point of view. He defined the ailment as "a species of melancholy, or a mild type of insan-

ity, caused by disappointment, and a continuous longing for the home. It is frequently aggravated by derangement of the stomach and bowels, and is daily met with in its worst form, in our military hospitals and prisons, and is especially marked in young subjects."

Peters found this affliction prevalent among young prisoners of war and also among fresh troops serving in the extreme South, where mail communications were irregular. The hospitals of New Orleans and its vicinity, he added, had been filled during the past summer with such cases, "complicated with fevers and diarrhoea." The majority of these cases were young men from the Eastern states, "where love of home and kindred is a characteristic trait."

The treatment of nostalgia would appear very simple [Peters said] could we always at its onset remove the exciting cause, by allowing the patient the free exercise of his will; but from obvious reasons this is usually an impossibility. The strict rules, usages and exigencies of military service are insurmountable barriers against granting too free indulgence to soldiers.

The surgeon must carefully attempt to relieve the patient's mind of its injurious burden by other means, such as kindness, free exercise, bathing and agreeable associations, while he improves the tone of the stomach and bowels by generous diet and tonics. In cases where complications exist, notwithstanding his zealous efforts, the symptoms will frequently baffle his skill and then as a *dernier resort*, and in order to save life, or prevent permanent disability, he must recommend the man's discharge from the service.

This problem was further discussed in a paper on "Nostalgia as a Disease of Field Service,"¹² by Dr. J. Thomas Calhoun, surgeon-in-chief of the Second Division, Third Corps, U. S. Army.

Calhoun stressed the methods of recruitment in the Union army as a principal cause of nostalgia among soldiers. At the beginning of the war, he said, the opinion was universal that the conflict would last but a short time.

Regiments were formed in a day or a week. Many, impelled by the noblest of motives, left their daily avocation without a thought for the future. Fathers left their families, husbands their wives, young men their heart's idols. . . . But the rough fare, the hard knocks of a soldier's life, will dispel an enthusiasm, although incited by the best of motives. Soon came a yearning to go home, the time they had expected to have been absent had gone by; their business was suffering, their families wanted them at home; they longed again for the luxuries to which they had been accustomed, a good bed, a cheerful fireside and the delicacies of the table. And now, as our armies are

¹² *Med and Surg. Reporter*, Vol. XI (1864).

recruited with unwilling men, either conscripted or bought up by enormous bounties, none of them animated by the patriotism or manliness of our early volunteers, we have every cause necessary to the production of nostalgia¹³

Calhoun referred to the Union troops as "emphatically a letter-writing army," and expressed the belief that the constant flow of correspondence between soldier and his family increased the yearning for home.

The prevailing policy of granting furloughs only as a reward for re-enlistment and for rare cases of grave emergency tended to bottle up these yearnings for home, Calhoun observed. "Is it strange, then," he added, "that men have sickened, and I doubt not died, from home sickness?"

Battle action was a great curative agent for nostalgia. Calhoun cited the case of a new regiment, the 120th, which had never been in battle, and which lacked esprit de corps. Many of its members were homesick. But at the great battle of Chancellorsville they had fought nobly. They gained a name, and had something to be proud of.

Their thoughts were turned from home, and they felt they were men and soldiers, peers of the veterans with whom they associated; and from that day to this there has been but little or no sickness, and but one or two deaths. . . . When men have passed through the baptism of fire together, they feel they have something in common. They have a common name, a common fame, and a common interest which diverts their thoughts away from home

Calhoun also advocated a generous furlough system as a means of alleviating serious homesickness. He related the story of how General Hooker had taken command of a demoralized army and immediately raised its morale to a high level by adopting a liberal system of furloughs as rewards.

"But when nostalgic patients in the field cannot be granted furloughs, cannot be laughed out of it, and there is no campaign in progress, they should be kept at work. Idleness is a provocative of home sickness. Let the patient be hard at work all day, and he will have a relish for his rations, and will sleep soundly at night, having little time to think of home."

The official *Medical and Surgical History of the War of the Rebellion, 1861-65*¹⁴ records a total of 5,213 cases of nostalgia among the white

¹³ *Ibid*, pp 130-132.

¹⁴ I, Part 3, 884

troops of the North during the first year of war, or 2.34 cases per 1,000. In the second year the rate rose to 3.3 per 1,000.

Diseases of the nervous system, according to figures presented in the *Medical and Surgical History*, ranked tenth among twenty-two causes of disease among Northern troops throughout the Civil War. Of the nervous diseases, epilepsy accounted for 28.3 of every 1,000 soldiers discharged for special diseases from January 1, 1861, to June 30, 1866; "paralysis" accounted for 20.8 per 1,000 of such discharges, and "insanity" for 6 per 1,000.²⁵

On the whole, general psychiatric problems were given but scant notice in the literature of military medicine during the Civil War. Only a few pages are devoted to mental and nervous diseases in the huge six-volume official medical and surgical history of the war. It is significant, too, that the subject is entirely omitted in the volume, *Military, Medical and Surgical Essays*, prepared for the U. S. Sanitary Commission, edited by Surgeon General William A. Hammond, and published in 1864.²⁶ Distinguished medical men contributed essays on such aspects of military medicine as military hygiene, control of infectious diseases, vaccination in armies, pneumonia, anesthetics, amputations, and venereal disease—but not a single section mentioned mental and nervous disorders. Similarly, Capt. Louis C. Duncan's work, *The Medical Department of the United States Army in the Civil War*,²⁷ lacks any reference to this subject.

Even more surprising is the paucity of references to military psychiatry in the *American Journal of Insanity* throughout the war years. Most of the contemporary psychiatric literature pertaining to the Civil War appeared in journals of general medicine. The conflict had but little impact on the contents of the *American Journal of Insanity* or, for that matter, on the tenor of the papers read at the annual meetings of the Association of Medical Superintendents of American Institutions for the Insane during that period. Organized psychiatry at the time was still confined to a small group of asylum heads, more or less isolated from the main streams of community life. No effort was made within or without the group to mobilize psychiatric talent for the war effort. It was the neurologists, rather than the psychiatrists, who participated actively in military medicine and who profited thereby in experience and knowledge.

²⁵ *Ibid.*, pp. 11, 27

²⁶ Philadelphia, Lippincott.

²⁷ Washington, 1911.

The outbreak of the Civil War did cause the cancellation of the annual meeting of the Association for 1861. A notice was sent out by the organization reading: "On account of the troubled state of the country, the sixteenth annual meeting of the Association of Medical Superintendents of American Institutions for the Insane, appointed to convene June 11, 1861, at Providence, Rhode Island, has been postponed for one year."¹⁸ The postponed meeting was duly held in Providence the following year.

Not a single paper on military psychiatry, so far as I can discover, was published in the *American Journal of Insanity* or presented before the Association during the whole course of the Civil War.

On May 10, 1864, while the Association was holding its annual meeting in Washington, D. C., the organization adopted a motion appointing Dr. Charles H. Nichols, Superintendent of the Government Hospital for the Insane (now St. Elizabeths), to call on Surgeon General Joseph K. Barnes—who had succeeded Dr. Hammond—to "tender the services of the members of the Association to assist in the care of the sick and wounded now at Fredericksburg." (The military hospitals in that Virginia town were at the time filled with soldiers who had been wounded in recent battles.) The offer of the assembled asylum superintendents was politely turned down by Surgeon General Barnes, who sent them a note reading: "Please accept the thanks of this Department for the cordial proffer of assistance, and assure the Association that should a more urgent necessity than now exists render it advisable, their offer will be gladly accepted."¹⁹

The minutes of the 1864 annual meeting contain an item of interest relating to Dorothea Lynde Dix, the great crusader in behalf of the insane, who had been appointed the first superintendent of nurses in the U. S. Army. It reads: "Miss Dix, being introduced, gave a very interesting and feeling account of the conduct, condition and heroic endurance of our wounded in the recent battles, as she had witnessed them in the visit she had just made to them in the field."²⁰

Several members of the Association rose at this meeting to discuss a shocking situation concerning the discharge of insane soldiers without any provision for their safe return home or subsequent care and treatment. The War Department, upon the request of Surgeon General

¹⁸ *Am J Insanity*, XVIII (1861), 96.

¹⁹ "Proceedings" of the Association, Eighteenth Annual Meeting, Washington, D. C., *Am. J Insanity*, XXI (1864), 115

²⁰ *Ibid*, p. 155

Barnes, had issued General Order No. 69 in 1863, prohibiting the discharge of insane soldiers by surgeons through certificates of disability. The intention was to put a stop to the practice of turning mentally sick men loose to find their own way home as best they might. It appears, however, that this regulation was widely ignored.

A motion was adopted by the assembled members for the appointment of a committee of three to confer with Surgeon General Barnes on the subject. Dr. Thomas S. Kirkbride, who presided over the meeting, thereupon named Drs. John P. Gray, Edwin H. Van Deusen, and William P. Jones to serve as the committee

This committee, in a letter to Surgeon General Barnes dated November 7, 1864, made a series of charges concerning neglect of insane soldiers. The letter said that they had been found wandering about the streets of cities, incompetent to provide for their wants or to find their way home. The committee cited the case of one soldier who had been passed along a long line of railroads by conductors. The man was nearly destitute of clothing. Attached to his hat was a card marked "Michigan." He was left at the depot at Kalamazoo to fend for himself. Another soldier was found in the woods in a helpless state, trying to get home. Still another, a Methodist minister who was a noncommissioned officer, left the army in Tennessee, insane, and finally found his way home to one of the Western states. On the way, he had lost his baggage, his watch and money, and most of his clothing. One insane soldier was found nude in the streets of a village.

The committee addressed some practical questions to the Surgeon General. What should be done with soldiers found under the aforementioned circumstances, as well as with those who became mentally sick on furlough? How could the latter be protected against the charge of desertion for overstaying their leave? Would the Government pay civil mental hospitals for taking such soldiers in and treating them? How would payment be made?

Two weeks later the Surgeon General sent a reply. He wrote that insane soldiers, found at large without protection of guardians, might be sent to the nearest asylum until arrangements could be made for transferring them to the Government Hospital for the Insane in Washington. Payment for their transportation and asylum board would be paid by the War Department, at the rate of seventy-five cents per day for keep. Should

²¹ *Ibid*, p. 150.

a furlough expire during active insanity, the Surgeon General added, the sworn statement of an asylum superintendent would relieve the soldier from the charge of desertion and secure his transfer, extension of furlough, or discharge. Insane soldiers were to be discharged upon a medical certificate of disability only when they had friends or guardians to provide for their safekeeping.

The Surgeon General pointed out that official regulations required that all insane soldiers be sent to the Government Asylum at Washington, that this institution had adequate provision to meet all the requirements of the service men, and that civil asylum superintendents could best cooperate by promptly arranging to transfer all their military patients there.²²

The annual reports of the Government Hospital for the Insane during the Civil War years contain some striking observations concerning the impact of the emergency on the mental stability of the military and civilian populations. As has been noted, St. Elizabeths, then under the superintendency of Dr. Charles H. Nichols, received the bulk of the psychiatric casualties among the Union forces.

In the annual report for the fiscal year 1860-61, the institution's Board of Visitors declared:

In proposing sums for the maintenance of the hospital the sudden and considerable increase of the number of admissions, especially from the army and navy, since the beginning of the current fiscal year, must be taken into account. . . .

The profound political agitations and alarms, and the domestic dissensions and ruptures, which are doubly incident to a national capital and a border region in time of civil war, must likewise render the number of indigent insane of the District of Columbia larger than was anticipated at the time of preparing our last annual statement on the condition, prospects and wants of the institution.²³

The expectation of an increased rate of incidence of mental disorder in the civilian population was not realized. The report of the Government Hospital for the Insane for 1862-63 notes with surprise that admissions of civilians during the two years of war, far from increasing, had actually decreased, in spite of the fact that the institution was "situated

²² "Instructions from the Surgeon General Respecting Insane Soldiers," *Am J Insanity*, XXI (1865), 462-467.

²³ Government Hospital for the Insane, *Report of the Board of Visitors and the Superintendent of Construction, 1860-61*, pp 17-18.

in the very midst of the perturbations of war." The report further observed that "this exceptional feature in the domestic strife of arms in which we are engaged" had also been commented upon by the medical heads of the two largest mental hospitals in the Northern states (unnamed). One superintendent was quoted as saying: "The war-excitement does not seem to increase the number of admissions. . . . Nor has the war given any peculiar character to the delusions of those admitted."

The other asylum head was cited as expressing gratification that the Civil War—sudden, unexpected, and of unexampled magnitude though it was—had not added materially to the number of insane.

Dr. Nichols, in his report for 1862–1863, attempted to explain this reversal of an anticipated increase in the rate of civilian insanity on the basis of uniquely American characteristics.

This important exception to the teaching of previous history cannot be accidental. It must be due to some peculiarities either in the character of our people or in that of the war itself. Americans are as subject as any other portions of the human family to those profound moral impressions and perturbations to which the religious sentiment, the ties of blood and friendship, and the pursuit of ambition render all men individually susceptible; but the people of no other enlightened Christian nation on the earth are as superficially moved as we are by those great political, social and material changes which affect men in masses or individuals in common with others. The frequency and magnitude of the changes we experience have exhausted a natural susceptibility to their influence when infrequent and novel. We are stoics in respect to the issue of questions and enterprises that for a time enlisted all our efforts, and the composure with which we, as a nation of politicians, have become accustomed to meet the ever-recurring vicissitudes of political fortune has doubtless prepared us to meet this great and real crisis in our national life, without the intense awakening of the passions which endanger the stability of reason.

Referring to the character of the struggle itself, we find the loyal mind deriving an incalculable moral support from the universal sense of the entire justness of the national cause, and an equally prevalent faith in its ultimate and complete triumph.²⁴

The same report includes a curious note, of a psychosomatic nature, on military maladies as observed in patients at the institution:

Excepting a small proportion of cases caused by intemperance, cranial injuries, tumors, and other organic cerebral affections necessarily sooner or later disturbing to mental manifestations, the insanity which occurs among the

²⁴ Government Hospital for the Insane, *Report for 1862–63*, pp 20–22.

volunteer and other soldiers from high latitude, campaigning in the lower latitudes of the same zone, appears to us to be in most instances one of the consequences of a depression of the vital forces. The best constitutions are subject to such *sthenic* diseases as pneumonia and acute rheumatism, but with the exercise of a fair amount of prudence they are often invigorated from the first active service in the field. The weaker of the men, uninured to a soldier's life, are overmatched by the privations, exposures and fatigues of active service. Especially when serving in a malarial region they first become thin and enfeebled, and then, upon some extraordinary exposure or fatigue in such a state of debility, there supervenes either an intestinal flux or a low form of fever, sometimes both as distinct diseases. It is in the course or at the close of this series of agencies which impair the strength and tone of the nerve system that unsound mental manifestations begin to exhibit themselves²⁵

The report for the year 1863-64 noted an increase in the number of military patients admitted to the institution. "During the year under review there has been a marked increase among the admissions from the army, in the proportion of recurrences of insanity and of cases of derangement supervening upon greater or less imbecility." This increase was explained by the hypothesis that "the latter accessions to the Union armies include a large proportion of men who are more readily affected by the exciting causes of insanity than were to be found during the first two years of the war."

The hospital authorities, in this report, took occasion to urge a better system of selective service as a barrier to mental breakdown in the armed forces. "The duty of the examining surgeons to give more critical attention to the mental character of the candidate for service, whether volunteer or conscript," they observed, "is the practical lesson to be derived from the facts just submitted."

It is obvious [the report continued] that if the recruit lacks the mental vigor and endurance necessary to receive and practice the discipline and instruction of a soldier, he will involuntarily betray both his companions and his country in the hour of battle—the hour of his supreme trial—and render worse than useless a costly novitiate. The acceptance of an incapable candidate for service and the exemption of a capable man are equally culpable frauds upon the country. The first is a gross cruelty to the individual, and the latter an equally gross partiality.²⁶

The report for the following year (1864-65) noted as an "extraordinary fact" that the number of civil admissions into the hospital during

²⁵ *Ibid*, p. 20

²⁶ *Report for 1863-64*, p. 94.

the four years of war had increased but 10 per cent over the four prewar years, although the permanent population of the District of Columbia had risen 100 per cent in the same period. Furthermore, Congress had enacted two bills during the war extending the range of the Government Hospital's civil ministrations. One directed the institution to receive all indigent, transient insane found in the District; the other ordered that like provision be made for all mentally sick civilian employees of the quartermaster's and commissary department of the Army, without regard to residence.

The evident diminution in the relative prevalence of insanity in the District accords with the history of the disease throughout the loyal states; and it is thought to show that the mind of the country was raised by the war to a healthier tension and more earnest devotion to healthier objects than was largely the case amid the apathies and self-indulgence of the long-continued peace and national prosperity that preceded the great struggle.²⁷

That observation harmonizes with subsequent reviews of the impact of war on civilian mental health in this country during World War I and World War II—at least up to the present writing.

The Government Hospital for the Insane during the fiscal year 1864–1865 received a total of 512 cases, of whom 83 per cent were military patients. The whole number treated during the year totalled 866. A little more than 40 per cent of this number recovered. Noting that the recovery rate was somewhat lower than it had been during the first two years of war, the report explained:

The high proportion of incurable cases among the soldiers who have formed so large a moiety of our population during the war, and the payment of bounties for recruits, began at the same time. The relation that these concurrent events bear to each other is obvious. The various bounties, particularly the large sums paid for recruits during the last year of the rebellion, stimulated the cupidity of recruit and substitute brokers to the exercise of an ingenuity and perseverance . . . in imposing upon the army senility and childhood for vigorous manhood, and imbecility for soundness of understanding, which, had they been displayed in the genuine service of their country, would have commanded the blessing of heroic patriotism.

It was found that recovered soldiers discharged from the hospital and service and paid off, and left to journey to their homes by themselves, were so frequently the victims, while on their way, of the diabolical arts of "drugging" and robbery, and then of literal sale as recruits or substitutes, that no such

²⁷ *Report for 1864–65*, p. 10.

patients were permitted to leave the institution during the last six months of the war, except under the personal protection of friends or officials²⁸

The psychiatric highlights of the period of the Civil War may be summed up as follows:

The course of war surgery gave great impetus to the infant profession of neurology—producing such outstanding pioneers as S. Weir Mitchell, William W. Keen, and William A. Hammond. Papers on nostalgia, malingering, and other subjects contributed, in a modest degree, to the extant knowledge of military psychiatry. The American Psychiatric Association—or the Association of Medical Superintendents of American Institutions for the Insane, as it was then known—remained markedly aloof from the conflict, judging by the discussions at its wartime meetings and the papers in its unofficial organ, the *American Journal of Insanity*. The Association did, however, officially protest against the shocking custom of discharging mentally sick soldiers from the Army and allowing them to find their own way home, unattended by guardians. Little interest was displayed in military psychiatry by the medical profession as a whole. The lack of adequate psychiatric screening in the draft process was sharply criticized by several medical writers. Abuses in the prevailing bounty system of recruitment, permitting induction of mentally sick men, were also noted in the medical literature. Civilian mental health, according to contemporary reports of the Government Hospital for the Insane in Washington, D. C., did not decline during the war years, as had been anticipated.

²⁸ *Ibid*, p. 11.

EDWARD A. STRECKER

II. MILITARY PSYCHIATRY: WORLD WAR I

1917-1918

THE plan of attack on the neuropsychiatric problems of World War I was well conceived, reasonably comprehensive, and ably executed. This was all the more noteworthy since in this country military neuropsychiatry was without benefit of experience.

The psychiatry of the fratricidal conflict of 1861 was too feeble to furnish resourceful support. The somewhat dubiously motivated Spanish War was scarcely more than a slogan, a few easy victories, a "bully-beef" scandal, and a dreadful epidemic of enteric fever.

Furthermore, in World War I the terrorizing and lethal properties of machines of war for the first time approached the saturation level of human nervous resistance. This writer's chief, Thomas W. Salmon, A. E. F., authoritatively observed: "The present war is the first in which the functional nervous diseases ('shell-shock') have constituted a major medico-military problem. As every nation and race engaged is suffering from the symptoms, it is apparent that new conditions of war are chiefly responsible for their prevalence."

Of necessity, even before we entered the lists, it was imperative that we learn what there was to be learned from the neuropsychiatric experiences of our Allies.

The energy and foresight of the National Committee for Mental Hygiene, in coöperation with the Rockefeller Foundation, bore fruit in the appointment of commissions under Stewart Paton, Pearce Bailey, and Thomas Salmon, who studied the problem at the Mexican border, in Canada, and in Great Britain. In March, 1917, the Surgeon General of the Army called a conference for an analysis of the data obtained.

The reports of the commissions constituted the first important contribution to the neuropsychiatry of a war in which we were about to engage on the scarred fields of France. At once it became obvious that the incidence of military neuropsychiatric disabilities can be most effectively reduced at the manpower source—the induction center. Here is a principle of such significance that whenever it is neglected, payment inevitably will be exacted from many postwar generations not only in terms of huge economic burdens but even more distressingly in terms of disrupted morale and human unhappiness, personal and social woe.

The report that Thomas Salmon submitted to the Surgeon General after his return from England remains a classic in the annals of military neuropsychiatry. The magnitude of the problem was delineated by such statistical detail as the following: A neuropsychiatric disability rate of 4 per 1,000 in the British Expeditionary Force; one fifth of the 200,000 British soldiers on the pension list suffering from war neuroses.

Salmon's recommendations were definite and practical; they included the establishment overseas of neuropsychiatric base hospitals; the operation of the psychiatric segment of the sorting center or triage; provision for small (30-bed) units in the advance section of the line of communications, for the observation and treatment of war neuroses; a psychiatric service of evacuation hospitals, the transportation of the soldiers, and their care in the United States.

Even more significant were Salmon's observations concerning the effect of these psychic wounds upon troop morale. His visualization of the concept of the emotional conflict underlying war conversion hysteria (the moving demands of the instinct of self-preservation stirring deep and strong affective currents vs. the conscious expectations, desires, and requirements of "soldierly-ideals" imbedded in an emotional matrix of discipline, patriotism, and the like) was so dynamic and stimulating that it served as a beacon light to every psychiatrist in France, no matter how dark the outlook. Perhaps no one psychiatrist had enough psychiatric information to foresee all the ramifications of military neuropsychiatry, but Salmon had something over and above mere formal psychiatry. His practical humanitarianism and ideals of service provided the ways and means and constituted a force more than sufficient to meet the complex issue successfully.

The creation of a Division of Neurology and Psychiatry in the office of the Surgeon General was the springboard of a comprehensive plan. It involved extensive preparation for the examination of recruits in the mobilization camps, looking to the detection of those neuropathically or psychopathically unfit for military service; the setting-up of adequate facilities for the observation and care of nervously and mentally sick soldiers, pending discharge, plans for places and methods of treatment for neuropsychiatric disabilities in the A. E. F., plans for treatment and disposition of soldiers invalided home from overseas.

At once it became urgently necessary that psychiatrists habituated to

the practice of civilian psychiatry accommodate their vision to medico-military perspectives and, furthermore, that they build an effective neuropsychiatric machine within the structure of army regulations, not always flexible.

The presenting problems were of the greatest diversity and all of them were important: The psychiatric, neurological, and psychological personnel of the country had to be quickly mobilized for service—trained women nurses and male attendants were needed at once for neuropsychiatric hospital units; methods of examining large numbers of men in a comparatively short time by the few available well-trained psychiatrists had to be devised; criteria for the rapid detection of too fragile neuropsychiatric human material had to be formulated; plans for various types of hospitals, including a standardized neuropsychiatric hospital, a 500-bed reconstruction hospital for overseas, 30-bed units to be attached to base and other military hospitals in France, had to be blue-printed; equipment for the hospitals had to be standardized and secured, forms and blanks for collecting, reporting, and analyzing statistical data had to be worked out and printed; arrangements had to be made for special intensive courses in war psychiatry and neurology for the additional training of young neurologists and psychiatrists; information pertinent to the situation abroad had to be collected and distributed for the guidance of those at work in the United States upon military neuropsychiatry; a policy concerning the psychiatric implications of disciplinary problems in the army had to be formulated; methods needed to be developed so that without too much friction neuropsychiatric units could be coordinated with the existing army medical machinery, and so forth.

In view of the fact that civilian psychiatry had no knowledge of military neuropsychiatry, and the army had no provision for a psychiatric organization, truly a very small David was set to slay a gigantic Goliath.

Effect inevitably follows closely upon the heels of cause, but in the administration, procurement, and distribution of neuropsychiatric personnel, enough wise counsel prevailed (largely through the helpful offices of the National Committee for Mental Hygiene) so that not too many false steps were taken and there was not too much stumbling. Easily there might have been chaos. The personnel in the office of the Surgeon General was scarcely competent to handle the intricate problems of neuropsychiatry, and there was a distrust of specialism.

As soon as war was declared it became evident that we would have to pay dearly for our myopia as to the importance of adequate undergraduate and graduate instruction in psychiatry and neurology. There was plenty of work to do, but there were not enough trained men to do it. At once plans were made to lessen the deficit, and six-weeks' intensive courses of instruction were given at the Boston Psychopathic Hospital, the Mendocino State Hospital, Talmage, California, the New York Neurological Institute, Philadelphia General Hospital, Phipps Psychiatric Institute, the Psychopathic Hospital at Ann Arbor, and St. Elizabeths Hospital.

It would be an error of omission not to record that serious mistakes were made. It was a grievous error late in 1918 to terminate the separate existence of neuropsychiatry and subordinate it to the division of medicine. One unfortunate corollary of this ill-advised step was the alignment of psychology to internal medicine, rather than a more utilitarian union with psychiatry. Neither military expediency nor military psychiatry was well served by a tendency to relax professional standards for psychiatrists. Too many of the precious few psychiatrically trained nurses were diverted to nonpsychiatric military nursing.

However, through the energy and skill of Thomas Salmon, Pearce Bailey, and others, many of these mistakes were rectified. The nursing department of Bloomingdale Hospital rendered yeoman service in raising army psychiatric nursing standards to a higher level. Draft Boards cooperated in allocating much needed psychiatric male nurses and attendants to psychiatric work. A few psychiatric aides were made available through courses at Smith College.

When it is remembered that at the time of the armistice there were in the service only 693 psychiatrists—430 in the United States and 263 overseas—it becomes evident that those who served succeeded in making three or four blades of psychiatric grass grow where only one grew before, and did it in a field new for the army and new for psychiatry. Only a few of the almost daily demands made upon psychiatry have been mentioned here.

The psychiatric contribution to the examination of student officers was significant, and I believe its sound influence was felt on every battlefield in France in terms of fewer military mistakes and better morale. Psychiatrists were helpful at ports of embarkation. Psychiatrists contributed wise guidance to Disability Boards

In my opinion the divisional psychiatrist was the vertebral column of

the military psychiatric service. His duties were manifold, as may be seen from the following order:

Duties of Medical Officers Detailed as Psychiatrists in Army

Divisions in the Field

Headquarters, American Expeditionary Forces

Office of the Chief Surgeon

France, January 15, 1918

1 The following outline naturally does not indicate all the means by which medical officers detailed as psychiatrists in army divisions in the field can be of service in dealing with the difficult problems arising in the diagnosis and management of mental and nervous diseases among troops. These officers are under the direction of the chief surgeons of the divisions to which they are attached, and they must be prepared at all times to render such services as he may require. These officers are not members of division headquarters staff. They are attached to the sanitary train.

2. It is essential for such officers to bear in mind the prime necessity of preserving, or restoring for military duty, as many as possible of the officers and enlisted men who may be brought to their attention. On the other hand, they should recommend the evacuation, with the least practicable delay, of all persons likely to continue ineffective or to endanger the morale of the organizations of which they are a part. This is particularly true in the case of the functional nervous disorders loosely grouped under the term "shell shock" but more properly designated as war neuroses. Psychiatrists detailed to this duty have a unique opportunity of limiting the amount of ineffectiveness from this cause and of returning to the line many men who would become chronic nervous invalids if sent to the base. At the same time they can bring to the attention of other medical officers and company commanders individuals who possess constitutional mental defects of a type which make it certain that they will break down under stress.

3. Specific duties which may be performed by psychiatrists in army divisions are as follows:

(a) Examine all officers and men under observation or treatment for mental or nervous diseases in regimental infirmaries, field hospitals, camp infirmaries, and other places, and advise regarding their diagnosis, management, and disposition.

(b) Examine other mental or nervous cases in the divisional areas when directed to by the chief surgeons or requested to by other medical officers or company commanders.

(c) Examine and give testimony regarding officers and men brought before courts-martial or under disciplinary restraint, when directed or requested by competent authority.

(d) Give informal clinical talks to groups of medical officers in the di-

visions to which they are attached upon the nature, diagnosis, and management of the mental and nervous disorders peculiar to troops

(e) Keep careful records of all cases examined.

(f) Make such reports to the chief surgeons of divisions as they require and to make monthly reports of their operations to the director of psychiatry, bringing especially to his attention any matters likely to increase the efficiency of this part of the medical work of the American Expeditionary Forces

A. E. Bradley

Brig. Gen., N.A., Chief Surgeon

Approved.

By Command of General Pershing.

J. G. Harbord

Chief of Staff

The mere listing of duties gives but an incomplete picture of the work of the divisional psychiatrist. He was doctor to a city of canvas and wood housing some 30,000 men. He was not only mental-health doctor to the soldiers; he was their friend and counselor. He lived with them, ate and slept with them, played with them, and upon occasion quarreled with them.

As far as I know I was the only divisional psychiatrist who had the interesting experience of being assigned to a division (the 28th) early in the war, having the opportunity of examining the division in this country, and then serving with it in the field in the A.E.F. Among other things this experience was chastening and conducive to proper psychiatric humility since, in spite of weeding out of too-fragile psychiatric material before embarking, there were still a large number of psychiatric breakdowns and casualties in France.

In order to continue the sequence of the story of the divisional psychiatrist, it might be helpful to follow him overseas to the battlefields of France. My own experiences may serve as an index to those of the other divisional psychiatrists.

Stationed, as the division neuropsychiatrists were, in combat areas, all their work being confined to field hospitals where patients were held only from three to ten days, depending upon military operations, the experience of these officers with the treatment and final outcome of the cases was limited chiefly to the milder forms of the neuroses. The more obstinate and chronic cases, of necessity, were evacuated to the rear areas.

The neuropsychiatric patient was sent to the treatment hospital at the

front after he had taken the first important step on the road to recovery. No one was sent there until a determined effort had been made to convince him that he could be cured. Of course, there was necessarily a constant and fairly large residuum of refractory cases, but these were not permitted to negate the atmosphere of optimism which existed. Although these treatment hospitals were situated in the field within the range of artillery fire, and subject to the military necessity of moving at an hour's notice, it was still possible to approximate suitable hospital conditions. The first difficulty which presented itself was the lack of nurses. The group of enlisted men who were selected for the work had in the beginning nothing more than the doubtful merit of curiosity concerning the "shell-shocked" soldiers, until it was possible to inculcate a certain degree of nursing morale, it was necessary to deal with them from the point of view of military discipline. Certain orders were given, and failure to obey was considered a punishable infraction of a military command. The few simple rules and suggestions utilized at first (in one division) are here quoted:

Rules for Psychoneurosis Wards

1. Each patient on admission to have a hot drink.
2. Each patient to have three full meals a day unless otherwise ordered.
3. Do not discuss the symptoms with the patient.
4. No one is permitted in these wards unless assigned for duty.
5. The rapid cure of these patients depends on food, sleep, exercise, and the hopeful attitude of those who come in contact with them.

From such an elementary beginning there gradually developed among the enlisted men who acted as nurses a high degree of interest and efficiency, and a generalized and successful effort to maintain intelligently certain therapeutic principles without which success would not have been possible.

Classification was an important function of this hospital. Generally speaking, there was an effort to keep the mild cases in one tent, the more severe in another, the physical problems separate, and the recovered awaiting return to the front apart from the others. Soldiers with obstinate symptoms were segregated. The physical needs of the patients were constantly borne in mind. Hot, abundant meals were provided; exercise, amusements, and work were utilized, not in haphazard fashion, but with a certain object in mind.

One finds in current reports on the therapy of war neuroses indefinite

allusions to an intangible and mysterious therapeutic influence termed "atmosphere." By this is meant, presumably, the general feeling and understanding which existed among all those who came into medical contact with the war neuroses and which were meant to provide an urge or incentive for the soldier to return to his duty on the firing line. This understanding was necessarily developed at every point in the American Expeditionary Forces where nervous and mental casualties were grouped for treatment. However, it should not have been permitted to remain at a vague and undefined stage, nor should its growth and direction have been left to mere chance. As a matter of fact, it was a thing which could be deliberately created and shaped into a definite and valuable therapeutic agent. As employed in the type of hospitals under consideration, it was divided roughly into positive and negative elements, the first being concerned with the advantages of returning to the front, and the second with the disadvantages of evacuation to the rear. Constantly, and in every conceivable fashion, were emphasized the glory and traditions of the division, of the regiment, and of the company, and the very important part which each soldier played in contributing his share. Further, the personal relation which so frequently existed between officer and soldier was in a sense filial, just as the intimate feeling between man and man was fraternal. In the field with combat troops, where close association under dangerous conditions made for the relaxation of certain features of rigid military discipline, such as ordinarily obtains in a cantonment or camp, and where social barriers were erased, it is exceedingly probable that what might be termed an artificial familial instinct was often developed and that it replaced in a measure the one of which the individual was at least temporarily deprived. This factor, too, could be utilized as a powerful means for obtaining a healthy therapeutic atmosphere.

On the other hand, evacuation to the rear was painted in gloomy colors. The patients came to realize that leaving the division, or unit, meant probably the opportunity forever lost of having a part in its present victories and consequently in future honors and rewards. Leaving the unit involved a total separation from the paternal officer and brother soldier, and finally becoming that most unhappy of mortals, a lone casualty. It was in a sense a desertion, since it left comrades to "carry on" alone.

It would be impossible to enumerate all the methods employed to foster and stimulate such impressions. The following samples will serve: informal talks to groups of soldiers; the announcing and publishing of

bulletins recounting the gallant advance of this or that unit, or the exploits of some well-known officer or soldier of the division; the reading and discussing of citations which had been received; rumors of a big offensive which was imminent, or of a well-earned rest which soon would be officially ordered, and the relating of incidents and episodes, "gossip" with a personal flavor, which had come back by word of mouth from the front. No incidental opportunity was neglected. For instance, during the Meuse-Argonne operation, columns of German prisoners frequently passed the tents. The patients were urged to view the procession, always a stirring event, which often succeeded in evoking an exhibition of satisfaction and even patriotic fervor. It is doubtful whether anyone who has not been an actual witness can appreciate the value of even such simple measures. The whole plan was far from being indefinite or purely improvised but was based on an estimate of what emotions and feelings were to be activated and what degree of stimulation was needed to gain the desired object.

It is difficult to understand why such a personal and concrete thing as the attitude of the psychiatrist toward each of his patients is so often described in such general terms. It was by far the most important feature of practically any form of treatment. Taking its cue chiefly from personality and intellectual capacity, it had to be rapidly defined in the mind of the physician so as to meet the needs of the individual under consideration. Further, frequently it had to be varied from time to time in the same case. It affected every phase of treatment, often dictating the mode in which specific symptoms were to be removed, modifying the explanation of the neurosis, and governing the methods utilized in the final rehabilitation of the soldier before his return to the front.

The particular methods of treatment utilized may be roughly divided into those applied to all patients, or to fairly large groups, and those applied to individuals. In the former case, methods largely depend for effect on the creation and maintenance of the right kind of military atmosphere, one which seeks to produce and encourage a desire to return to the front. In this respect the following observations may be of interest: A certain type of soldier, often of a moderately high intellectual grade, not infrequently presented a curious psychological paradox as the time for his return to the front approached. He had made a good symptomatic recovery, had a considerable degree of insight into the mechanism of his neurosis, may have expressed a wish to go back to his regiment, and yet

may have found a marked difficulty in taking the final step. This was not due to the fact that he was distinctly unwilling to return to duty, for he would have been as much or even more troubled by a decision which would have evacuated him to the rear. Apparently, there was in these cases a temporary volitional paresis. This condition was observed in a small percentage of all the neuroses. Experiments along the lines of logical reasoning and appeal to the individual had little result, and it was decided to try the effect of another plan. When a sufficiently large group had been collected, the men were gathered together in a tent and given an informal talk, which was little more than an effort to reach and sway the emotions. Beginning with a recital of the situation at the front with reference to the division, and particularly to the various units which were represented by the soldiers present, the talk emphasized the acute need for every available man and the fact that comrades were suffering because of their absence, and finally came to a climax in a dramatic request for volunteers for immediate service. The result was always highly gratifying, and the spontaneous enthusiasm showed that these men were actuated by something more than mere deference to the wishes of an officer.

In another group of patients who had made a fairly good symptomatic recovery, or who persistently retained a few insignificant symptoms, the question of volitionally withheld cooperation arose. Two courses were open. The power of the military machine might be invoked to force action, reducing the matter to a choice between front-line duty or court-martial. This method was not employed. Its permanent value is not only questionable, but it is open to objections on ethical grounds. However, that the problem was no longer strictly a medical one had to be recognized. Although such men were not treated with undue severity, or with any malice, they soon found that an invisible barrier had been erected between them and the other patients. They were denied certain privileges and had to do most of the distasteful work, such as policing the grounds, digging latrines, and the like. No one was permitted to impugn their motives, yet on every side they were confronted by a questioning attitude. Always the opportunity was afforded them, and indirectly encouraged, to talk over the situation with one of the physicians, always there was the invitation and the temptation to change their status to a happier and more honorable one. About 90 per cent of this group were eventually reached by such a simple method.

For the attack on individual symptoms, resort was made to the various

forms of suggestion which have been described in detail by a number of authors. Whenever there was a choice between two methods, the simpler was always preferred. Complicated procedures seemed unnecessary. Often nothing more elaborate than passive relaxation of flexion and tension plus appropriate suggestion was needed to remove tremors; indeed, many of them disappeared spontaneously. If a paralysis responded at all to passive movement which gradually became active by the imperceptible withdrawal of the assisting hands of the physician, electricity was not employed. If a hysterical deprivation could be reached by suggestive persuasion or argument, such "tricks" in the use of the stethoscope, tongue depressor, mirror, etc., as were in vogue were avoided. There were, of course, times when a degree of mystification was necessary, but it was never the first resort and was usually reserved for more refractory symptoms. Hypnotism was never used.

As a preliminary to the consideration of the individual symptoms, there was an estimate of how much of the symptom was real and how much was only apparent. A change of the patient's position to one making for greater physical comfort, the removal of constricting clothing or of an external source of irritation, a hot drink, and a reassuring word or two were sometimes in themselves sufficient to decrease materially the range of tremors, to improve an exaggerated posture or movement, or to reveal a seeming paralysis as only a paresis. The amount of amnesia, particularly, always appeared greater than it really was. Before any intensive attempt was made to treat amnesia as a symptom, its extent was carefully gauged. A simple and brief series of questions and answers often strikingly diminished its apparent proportions. The selection of a route to gain access to any sign or symptom which presented itself in a patient was much influenced by the attitude which the psychiatrist had decided on as best suited to meet the patient's needs as an individual.

When more refractory symptoms were to be dealt with, that which seemed the most obvious thing to do was attempted first. Strict segregation had a wholesome effect on obstinate tremors or convulsive movements. Every advantage was taken of possible modifications of classification. A patient with a persistent difficulty would be placed for a short time in the midst of a small group of recovered soldiers awaiting transportation to the front. Occasionally someone who had made a particularly striking recovery was kept for a few days as a sort of hospital "pet" for the sake of the effect on difficult cases. He was taken into the confidence of the psy-

chiatrist and instructed as to what was expected of him. Now and then a "chronic" patient was permitted to observe the removal of some symptom in a recent case. Sometimes the physician planned to have his conversation and opinions overheard by this or that individual. At times, when dealing with troublesome symptoms, it seemed advantageous, after the patient's curiosity had been aroused, to postpone the final seance a number of times. A few elaborate consultations were staged wholly for their psychic effect. Such instances as the above might be endlessly multiplied, they merely served to intensify suggestion and were therefore useful.

The employment of simple procedures had several advantages. They needed no elaborate paraphernalia and did not demand lengthy preparation. In the field, space and time had to be carefully conserved. Moreover, it must be remembered that the patients, as they came to the triage, were like closed books. The soldier himself was frequently the only source of information available, and consequently there were many gaps in the history. When dealing with an individual whose potentialities were largely unknown, it seemed the part of wisdom to restrict oneself, if possible, to things which could do no harm. Some of the more complex forms of technique depend largely for their suggestive value on the veil of mystery which surrounds them. Unless absolutely necessary, as was the case in some unusual instances, explanation was avoided. Such an explanation is apt to prove embarrassing when the time comes to give the patient an account of his neurosis, when, of all times, the physician needs to be sure of his ground. This account, too, had to be as simple as possible. However high the educational and intellectual standard of the enlisted men in our army might have been, it did not reach the point where an involved discussion of psychopathological mechanisms could be appreciated. Even primary ideas and illustrations had to be used with caution, and the test of their efficacy rested on whether they were easily comprehended by the patient and satisfied his needs.

Of 400 war neuroses, embracing all types and occurring in different operations at the front, approximately 65 per cent were returned to front-line duty after an average treatment period of four days. During the second half of the Meuse-Argonne operation, the recovery rate amounted to about 75 per cent; earlier, along the Ourcq, it had dropped to as low as 40 per cent. This fluctuation was influenced by military necessity, there were four separate hospital-evacuation orders which affected about seventy patients who had had less than 36 hours' treatment—it is reasonable

to assume that at least one half of this number would have recovered if it had been possible to retain them 48 hours longer. After the armistice was signed, an effort was made to determine the number of times a second attack had occurred among the 65 per cent returned to the front. Only nine recurrences were found—less than 4 per cent. It is possible, of course, that a few cases may have passed through the triages of other divisions. However, these would necessarily have been restricted to troops on the flanks of the line and their number therefore could not have been significant.

The recovery rate was influenced by certain factors. From the type of symptom present, one could often predict the ease or difficulty which would attend its removal. Generally speaking, those patients with symptoms which had occurred in conditions where there had been a definite trauma, or emotional insult succeeded by a stage of relaxed consciousness, responded readily. They were frequently of a hysterical variety. On the other hand, those symptoms accompanying states which had been evolved in the plane of consciousness were not so accessible. They were apt to have a neurasthenic or psychasthenic coloring. Anxiety symptoms of various kinds presented the knottiest problems, and a relatively high percentage of patients with such symptoms had to be evacuated to the rear.

When time is necessarily limited, the rapidity with which contact can be established between patient and physician is an important consideration. The degree of inaccessibility in the make-up of the soldier will be reflected in the therapeutic failures recorded in the field. The responsibilities of the psychiatrist were clear. He had to return as many men as possible to duty, and during times of great activity it was not always feasible to give each patient the full amount of attention his condition deserved. In this way, and at these times, the individual whose personality involved careful and extended study in order that his neurosis might be reached sometimes had to be neglected as a matter of military economy.

The intellectual status of the patient was not without its effect. The relatively ignorant soldier was usually softer clay in the physician's hands than was the one in whom learning and training had sharpened the habit of questioning, scrutinizing, and weighing in the balance. Of course, these two often developed different types of neuroses but, given the same condition in both, the former could be handled with far greater rapidity and more surety of success.

Finally, the recovery rate fluctuated in response to extraneous and

wholly accidental factors. It was appreciably higher at periods when the division was about to be relieved, and it was lower at the beginning of what promised to be a long campaign. During the three or four weeks preceding the armistice, when victory followed victory on every front and definite success seemed assured, the recovery rate reached its apex. The psychological effect of such incidental happenings, of course, was complex; but in general they lessened the activity and the need of close surveillance on the part of the preservative instinct by the intrusion of new and attractive possibilities—the anticipation of rest and pleasure in different surroundings under safe conditions or the prospect of an early return to the United States as a member of a victorious fighting division, and a resumption of all those pleasant relations from which the soldier had been cut off by the war.

A statement of experience with the war neuroses would be incomplete without some reference to gas hysteria and its treatment. A striking instance occurred during the Aisne-Marne operation, when the 3d Division was in the neighborhood of the Vesle River. One morning a large number of soldiers were returned to the field hospital diagnosed as gas casualties. The influx continued for about eight days, and the number of patients reached about 500. The divisional gas officer failed to find any clinical evidence of gas inhalation or burning, and the psychiatrist was given an opportunity to act as consultant. The patients presented only a few vague symptoms. There were, perhaps, four or five instances of aphonia, but in the average case the symptoms presented were a feeling of fatigue, pain in the chest, slight dyspnea, coughing, husky voice, an assortment of subjective sensations referred to the throat, varying from slight tingling to severe burning, and some indefinite eye symptoms. Physical and neurological examination was practically negative, and the mental findings were inconclusive; if anything, there was an undercurrent of mild exhilaration. Most of the patients had the fixed conviction that they had been gassed, and they would usually describe all the details with convincing earnestness and generally with some dramatic quality of expression. Careful inquiry elicited the information that these soldiers came from areas in which there was some desultory gas shelling which, however, never reached serious proportions. The amount of dilution was practically always great enough to provide an adequate margin of safety. It further developed that these conditions were always initiated in about the same way. Either following the explosion of a gas shell, or even without this preliminary, a soldier would give the alarm of "gas" to those in his

vicinity. They would use their masks, but in the course of a few hours a large percentage of the group would begin to drift into the dressing stations, complaining of indefinite symptoms. It was obvious on examination that they were not really gassed. Further, it was inconceivable that they should be malingerers. They came from battle-tested troops, veterans of the severe action on the Marne and the early hard fighting in the Aisne region. It is highly probable that a number of factors which existed at that time acted together with the general effect of lowering morale and reducing inhibition to a state where any suitable extraneous opportunity was apt to be utilized by many as a route to escape from an undesirable situation. It differed from the manifestation of the personal instinct for preservation in that it was in a sense a mass reaction and a subconscious rejection of a situation which, although decidedly uncomfortable, yet was not sharply threatening from the standpoint of physical danger. The troops were more or less inactive—practically, they were merely holding a position—and the small amount of activity which occurred was more irksome and irritating than highly dangerous. Following on the heels of the advance at Chateau Thierry and the first rush in the Aisne region, the daily routine was comparatively monotonous and lacked all those stirring and dramatic qualities which even in modern warfare attend more important military operations. Further, instead of a definite, easily understood objective such as the soldiers had been accustomed to, the minor activity taking place seemed to them indefinite, uncertain, and apparently not aimed at a clear-cut objective. Again, too, for some time there had been a wide spread feeling that the division was soon to be relieved and given a well-earned rest. When the day came on which the order for relief was expected and word arrived that it was to be indefinitely postponed, the feeling of optimism gave way to disappointment and dissatisfaction. The relative inactivity gave abundant opportunity for endless discussion among the men, by which the mental unrest and uncertainty were rapidly disseminated and intensified. Finally, the troops were beginning to feel the physical strain of four weeks' exertion under the most exposed and trying conditions. When these factors, no one of which alone was sufficiently strong to account for the results, accumulated and were combined, they were evidently powerful enough to produce a wholesale effect.

The problem demanded immediate and energetic attention. It was obviously impossible to deal with each patient from the personal angle and give him extended individual attention. The drain on man power

was being felt, and military superiors had requested that these men be returned to the line as quickly as possible. On admission each man was examined, assured that his symptoms were not serious, and given some simple suggestive treatment followed by hot food and a brief rest. Some hours later he was again examined, encouraged to feel that the treatment had had the desired effect, complimented on his improvement, reassured about his condition, and convincingly told that he would be able to return to duty on a certain day at some specified hour. From this point on, symptoms were practically ignored. The patient now passed to a second tent where the conditions were rigidly military. Soldiers were usually required to wear their uniforms and to observe all military courtesies, and they were under strict discipline. There was a round of duties to be performed under the supervision of a noncommissioned officer. In short, the hospital lacked about the only desirable feature which was to be found at the front, namely, a relaxation of certain elements of military rule and routine duty.

This method was successful. Only an occasional case proved refractory and required more intensive work. The basic idea was an attempt to impress on the patient's conscious mind that his ailment was not serious, and on his subconscious mind that the situation in which he now found himself probably offered no great advantages over the one he had recently left. No harshness was permitted, but no opportunity was given to lose contact with the life, duties, and responsibilities of a soldier. The wave of gas "hysteria," as the line officers insisted on designating it, receded from day to day, and ceased spontaneously at the end of eight or nine days.

When hostilities ceased, there was some doubt as to whether the services rendered by divisional psychiatrists were sufficiently valuable to justify their retention in the divisions. In the army of occupation, where there was a possibility that divisions might again be engaged in combat or at least be liable to a long period of service on foreign soil, no such question was raised. The other divisions, however, went back into areas previously used for training, and as rapidly as possible were sent to various concentration centers in preparation for their return to the United States.

During this period of waiting for return to the United States, a great many policies which had been considered of importance during the period of combat were reversed. For instance, it was unwise to conduct too vigorous a search for mentally defective or psychopathic individuals in organizations about to return to the United States, as their discharge

from the army in any case was only to be a matter of several weeks. The mentally sick, of course, were sent—as before the armistice—to Base Hospital No. 214 at Savenay, from there they were returned to home territory, where they were further hospitalized or discharged from the service on surgeon's certificate of disability. After the armistice the war neuroses ceased to be a problem.

It should be recorded that the divisional psychiatrists were almost never diverted to nonpsychiatric medical service. Their chief duty in the field was the sorting of neuropsychiatric casualties—retaining the quickly recoverable group for treatment near the front, and arranging for the speedy evacuation of less favorable cases. It was officially recorded that the duty of the divisional psychiatrist was “the cure of mild psychoneurotic cases by persuasion, rest and treatment of special symptoms at a time when heightened suggestibility may be employed to advantage instead of being permitted to operate disadvantageously.”

Should a divisional surgeon disregard this order he incurred at once a reproof from the chief surgeon.

American Expeditionary Forces
France, September 8, 1918

From: Chief Surgeon

To: All Division Surgeons.

Subject Psychiatrists, urologists, and orthopedists in tactical division.

There is apparently some misunderstanding among division surgeons relative to the duties and status of specialists assigned to divisional formations for duty.

During the recent activities one division surgeon assigned the psychiatrist to dressing the slightly wounded. While he was engaged at his work, several hundred cases of slight war neurosis were evacuated that would never have left their division if they had been examined by a trained psychiatrist.

The above instance is cited to show the importance of properly utilizing the services of these trained specialists with a view in this instance of avoiding a repetition of the experiences during the recent activities when a total of nearly 4,000 cases of slight war neurosis were evacuated to base hospitals that should never have left their divisions.

(Signed) M. W. Ireland

Major General, Medical Corps, Chief Surgeon

Eventually the neuropsychiatric service for the men in the field was completed by the appointment of corps and army psychiatrists.

It must be borne in mind that psychiatry was no more prepared for war than were other special branches of service, notably the Air Forces. In order to produce the divisional psychiatrist and other psychiatric person-

nel needed to operate the machinery which was set into motion each time a neuropsychiatric disability tag was affixed to a casualty, much preparation and training were needed.

As far as treatment facilities were concerned, our woefully small army was caught flat-footed at the outbreak of hostilities. Previously, it had been necessary to provide for an average annual admission rate of only two hundred mentally sick soldiers. The original army hospital plans are perhaps indicated by the neuropsychiatric ward labels—"Isolation Insane." Naturally, such an archaic designation could not withstand the storm of disapproval from reserve officers recruited from the modern psychiatry of civil life, and the designation was altered to "Psychiatric Wards."

Reasonably soon neuropsychiatric wards were established in general hospitals at Plattsburg, New York, Fort Porter, New York, Danville, New York, East Norfolk, Massachusetts, Williamsbridge, New York, Walter Reed (Washington), Hospital No 6 at Fort McPherson, Fort Sam Houston, Des Moines, Iowa, and Letterman General. The first four of these hospitals received patients from overseas from the beginning of the war, and later hospitals at Fort Benjamin Harrison, Indiana, Fort Sheridan, Illinois, and one ward at Fort McHenry Hospital, Baltimore, were added. The hospital at Plattsburg was used for the treatment of war neuroses and established an excellent record.

The returning soldiers were landed either at Hoboken or Newport News. One cannot record that the neuropsychiatric program proceeded without hitch and that the psychiatrically disabled were swiftly allotted to the proper treatment facility. Many of the diagnoses which accompanied the soldiers were decidedly sketchy. By no means could this be solely attributed to regular army medical officers; rather too often reserve officers were at fault. Up to June 30, 1919, the following neuropsychiatric cases had been returned from overseas:

	<i>Total</i>	<i>Hoboken</i>	<i>Newport News</i>
Psychoses (insanity)	3,597	2,715	882
Constitutional psychopathic states	504	149	355
Epilepsy	416	302	114
Mental deficiency	762	410	352
Psychoneuroses	2,888	1,675	1,213
Alcoholism	51	51	—
Drug addiction	6	6	—
Recovered	95	95	—
Total	8,319	5,403	2,916

The total number of neuropsychiatric disabilities in World War I was 69,394.

The war yielded approximately 5,000 neurosurgical cases. It was unfortunate that these cases were largely retained on general surgical services; there was considerable waste motion in ordering neurosurgeons to army surgical hospitals. Many of these disabilities should have been operated upon promptly. With spontaneous wound healing the outline of the clinical picture was usually changed.

Thus, at the close of the surgical wound period, injuries to the nervous system become, as a class, neurological cases. But a change in clinical status would have been difficult to recognize administratively. It was not done in the British medical service, and it would have been impossible under the organization which obtained in our Medical Department. The original plan, as devised in the Surgeon General's Office, was that all these cases would be cared for in the United States in one or more special hospitals, under the brain section of the division of head surgery. But when these cases began to be returned in so much greater numbers than had been anticipated, it was found that the provisions for their care in the special hospitals established for the purpose at Cape May and Colonia, New Jersey, were inadequate both as to the number of beds and as to qualified personnel. And, in addition, it was found that civilian interests demanded a wider distribution than had been provided for. These patients, like most all the others, wanted to be somewhere near their homes. It became necessary, accordingly, to increase the hospitals designated for their special care. More than a dozen, geographically well-separated, general hospitals were therefore designated for patients of this class on their arrival from overseas, the choice of the particular hospital being made with reference to its nearness to the patient's home. The division of head surgery in the Surgeon General's Office, having so many of its officers overseas, could not expand its personnel to meet this situation, and as there was no neurological service in the hospital organization of the Medical Department, the patients automatically fell to the division of general surgery, to which were assigned such neurologists and neurosurgeons as happened to be available.

As far as psychiatry was concerned—as might have been anticipated—it had to sell itself to the "old-timers" among the regular army medical officers and the line officers. At the beginning the sale was not easy to make. On disability boards nonpsychiatric officers were often afraid that psychiatrists were being impractical and "soft," instead of realizing, as they

did a bit later, that the psychiatrists were trying to build a psychiatrically fit army. However, the problem solved itself as soon as it was discovered that nervously unfit men were being included in the A. E. F.

On July 15, 1918, General Pershing cabled to the Chief of Staff as follows:

Prevalence of mental disorders in replacement troops recently received suggests urgent importance of intensive efforts in eliminating mentally unfit from organizations new draft prior to departure from the United States. Psychiatric forces and accommodations here inadequate to handle a greater proportion of mental cases than heretofore arriving, and if less time is taken to organize and train new division, elimination work should be speeded.

Upon the Surgeon General's receipt of this information, the matter was taken under consideration by the chief of the division of neurology and psychiatry, and the following information, based upon reports made to the Surgeon General by neuropsychiatric examiners, was submitted to the Surgeon General by the chief of the division, with his recommendations.

1. Apropos of the attached cablegram from General Pershing, the following data are submitted. A survey of the records in this office shows that the divisions that have gone abroad have carried with them the following number of men who had been recommended for discharge as unfit for military service by the psychiatric examiners:

<i>Division</i>	<i>Number of Men</i>	<i>Division</i>	<i>Number of Men</i>
4th	48	77th	5
27th	21	78th	208
28th	93	79th	73
29th	166	80th	90
30th	152	81st	3
31st	52	82d	120
32d	32	83d	53
33d	44	84th	38
34th	21	85th	45
35th	181	86th	53
36th	138	87th	198
37th	271	88th	29
38th	130	89th	115
39th	244	90th	44
40th	25	92d	70
42d	273		
		Total	3,035

2. The men enumerated above are epileptics, dementia praecox, general

these men are totally unfit for military service, and become a burden upon the Government either immediately upon landing, or shortly afterwards. The psychiatric service abroad is equipped only to care for men who become incapacitated in line of duty. Three thousand cases thrust upon this service almost en masse will tax the resources seriously, as it is evident has been done from the cable of General Pershing.

3. Attention is called to the fact that the numbers of cases carried over by different divisions differ markedly. Three divisions (41st, 76th, 91st) carried no men who had been recommended for discharge. The 81st carried 3; the 77th, 5; the 42d, 273; the 37th, 271, the 39th, 244, etc. It is evident, therefore, that the S. C. D. boards in the different camps vary either in the importance they attach to nervous and mental disease, or in the expedition of their work. Complaints have frequently been received on the length of time necessary to discharge men who have been recommended to the boards. An inquiry recently made in a few camps shows the following variations in time.

Camp Dix, average time 5 days.

Camp Jackson, previous to July 1, average time 24 days, since July 1, 12 days.

Camp Fremont, 21 days.

Base Hospital, Alexandria, La., 23 days.

4. In order to obviate the difficulties arising in the American Expeditionary Forces, as mentioned by General Pershing, it is suggested that an effort be made to expedite S. C. D. proceedings, and that the importance of excluding recruits who are nervously and mentally unfit for service be drawn to the attention of S. C. D. boards.

Professional, personal, and even military relations between psychiatrists and medical and line officers thereafter became increasingly better, and eventually it was one of the most satisfactory and productive liaisons of the war.

There is abundant testimony to the effect that psychiatrists labored tellingly to keep psychiatrically fragile material out of the army. Prior to February 1, 1919, there had been returned from the American Expeditionary Forces 4,039 cases of nervous and mental disabilities, a small number when it is considered that nearly 2,000,000 troops had been sent overseas, and especially when deduction is made of the 3,181 soldiers who were sent overseas in the face of psychiatric recommendations to the effect that they were not fit for military service of any kind. The rates of insanity, suicide, and delinquency in the American Expeditionary Forces were extraordinarily low for an expeditionary campaign.

The accuracy of the examinations is attested by the fact that there was substantial agreement in results at different points, by the fact that they coincided almost exactly with the results recorded in the reports of the

local boards as prepared by the Provost Marshal General of the Army, and by the fact that individuals detected and discharged at one camp were later again detected and discharged from another camp to which they had been sent. Local draft boards did not always take the rejection of recruits as final, and when called upon for another increment of men would include in this increment, to be sent to another camp, men rejected at the first camp as nervously or mentally unfit. Records were received in the Surgeon General's Office of men detected and discharged from as many as five different camps, each time by a different group of examiners.

Considering the lack of previous preparation and set-up and the dearth of personnel, the base hospitals rendered very satisfactory psychiatric service. Base hospitals were established at the following camps: Sherman, Ohio, Devens, Massachusetts, Wadsworth, South Carolina, Meade, Maryland, Jackson, South Carolina, and Grant, Illinois.

Occupational therapy deserves particular mention and, all in all, it was the most valuable adjunct to treatment. Psychiatric social service turned in a very creditable performance, particularly at Plattsburg. Plattsburg established an excellent record in several directions: Concerted and intensive attention to the psychoneuroses resulted in a return to duty of 27 per cent of the first 1,000 cases treated, the rehabilitation of soldiers disabled by the aftermaths of meningitis constituted a distinctive contribution.

Additional psychiatric treatment units were in operation at General Hospital No. 1 in New York City, in which Ward Number 55 was opened in November, 1918, for the reception of neuropsychiatric casualties cleared through the port of Hoboken. Some of the casualties were sent to Debarkation Hospital No. 51 and the National Soldiers' Home, Hampton, Virginia, converted into U. S. General Hospital No. 43. At the latter it was noted that a certain group of apparently malignant schizophrenics made very satisfactory recoveries. This clinical report was verified in other hospitals, and an important concept was validated: The impact of war may be sufficiently strong to produce a temporary psychotic disorganization of the personality.

As might have been anticipated, psychiatry was at first not received with open arms when it offered assistance in meeting military delinquency and disciplinary problems. However, certain incidents, including the behavior of a general who developed a manic state, and a ranking officer in France in whom a psychiatrist discovered parietic stiff pupils,

helped to smooth the way. Eventually, psychiatry became more or less of a Benjamin in the medico-legal problems of the army. At the Fort Leavenworth disciplinary barracks a psychiatric course was given.

It is worth recording that of 3,000 prisoners there, 436 were conscientious objectors and the whole group was of average intelligence, of 3,028 prisoners, 2,088 were "egocentric," 728 "inadequate," 216 "emotionally unstable." Thus in World War I the lesson was thoroughly learned that the constitutional psychopathic inferior cannot by any of the devices of psychiatry be made adequate for military service. It seems unfortunate that this lesson had to be expensively and sadly relearned in World War II.

The focal point for psychotic soldiers was St. Elizabeths Hospital. Naturally, as the incidence rose, the capacity of the government hospital reached the saturation point. Some of the patients were distributed to the neuropsychiatric wards of base hospitals; some milder cases were returned to their homes. Through the coöperation between the National Committee for Mental Hygiene and various state hospitals, a larger number of patients were cared for in their own state mental hospitals. The majority of the neuropsychiatrically disabled soldiers, as beneficiaries of war risk insurance, became wards of the United States Public Health Service, and eventually were cared for by the Veterans' Bureau. The financial cost per veteran was in excess of \$30,000, and the total expenditure for neuropsychiatric disabilities has exceeded one billion dollars.

The psychoneuroses constituted the most significant problem in the psychiatry of World War I. In the United States encampments more than 11,000 instances were identified. Overseas the psychoneuroses occupied three tenths of the psychiatric casualty sector (30 per cent), as compared to 16.5 per cent in the home mobilization centers.

In the United States the more common psychoneuroses among white soldiers were neurasthenia and psychasthenia; among Negro soldiers hysteria and stammering constituted 70.7 per cent of the neurotic reactions. Of all the psychoneurotic soldiers, 95.1 per cent had had symptoms before entering military service. To return to the problems in the A. E. F., where our army was participating in a telling way on the battlefields of France, many of our soldiers made the supreme sacrifice, many sustained battle wounds, many were just as honorably incapacitated by wounds of the psyche.

In order to care efficiently for the large number of neuropsychiatric

casualties, a competent and smoothly functioning organization was needed. The beginning of a well-defined neuropsychiatric service in the American Expeditionary Forces may be said to date from December 24, 1917, when a director of psychiatry was appointed. A medical officer, who had been assigned to duty in England to study the treatment of war neuroses, was shortly afterward assigned as assistant in the office of the director of psychiatry.

The newly organized neuropsychiatric service found plenty of urgent tasks. It was apparent that no time could be wasted in providing for neuropsychiatric work in the tactical divisions, if the American forces were to avoid the heavy toll of casualties from functional nervous disorders that had earlier been borne by other armies in the field. Although chief reliance had to be placed upon the assignment of a consultant in each tactical division who could help in the task of dealing with war neuroses at their very inception, there was no provision in the military organization for such an extra medical officer. Early in January, however, the War Department approved the plan that had been devised in the American Expeditionary Forces for the provision of a divisional neuropsychiatrist, thus making it possible to assign to each combat division "one specialist in nervous and mental diseases."

The instructions in this connection applied to the United States; however, they permitted division psychiatrists to be detached by the commander in chief, A. E. F., upon the arrival of divisions in France, if that seemed to be desirable. It was for this reason that these officers were not included in the tables of organization, a factor which gave rise to some difficulty later on. Fortunately, there was no disposition on the part of the chief surgeon, A. E. F., to recommend the psychiatrists' detachment, although some of the division surgeons felt that, being attached to a field hospital, their work should be confined to such an organization so that they could help, if needed, in every regiment, train, and company. Had it been possible to foresee this handicap, division psychiatrists would have been attached in the first place to the office of the division surgeon, as was done later with practically all divisional consultants by the division surgeons on their own initiative. On September 8, 1918, a communication from the chief surgeon, A. E. F., to all division surgeons directed that divisional consultants "should be attached to the office of the division surgeon as additional assistants," thus confirming a status which, in most instances, had already been granted.

In January, 1918, there were in France five divisions (1st, 2d, 26th, 41st, and 42d). All but the 41st were in training areas centering in Chaumont, the location of general headquarters, A. E. F. Neufchateau, headquarters of the professional services, was forty miles from Chaumont and quite as convenient a center for work in the training areas. The problem was to find psychiatrists for assignment as division consultants. Fortunately, in July, 1917, seven medical officers who had had special training in nervous and mental diseases had been sent to England to observe the treatment of war neuroses in the different British war hospitals. Orders were secured for four of these officers, all of whom were men with high professional and personal qualifications, to report to the divisions then in France. By the middle of January all four had been assigned to duty.

In the latter part of April, 1918, a new plan was put into effect by General Orders, No. 88, G. H. Q., under which the directors were termed senior consultants in the various specialties, and the medical and surgical groups were put under the general direction of a chief consultant in medicine and a chief consultant in surgery, respectively. The former directors became senior consultants, A. E. F.; consultants, A. E. F., were also provided.

In the division of neuropsychiatry, an assistant director of psychiatry, A. E. F., who had been appointed April 10, 1918, now became consultant in neuropsychiatry, A. E. F. Although the considerations that had led to the establishment of the immense hospital centers in the American Expeditionary Forces were chiefly of an administrative nature (for example, the great amount of material needed in the construction of long sidings for the American hospital trains that brought the wounded from the front), the chief surgeon, A. E. F., had not lost sight of the fact that professional services in the hospitals constituting these centers could be supervised effectively by a consultant in each of the more important specialties. Some of the most distinguished American physicians and surgeons served in this capacity, with great advantage not only to the sick and wounded but to the other officers in their specialty who found encouragement to conduct their work on the highest possible level.

By August 1, 1918, neuropsychiatric consultants had been assigned to Base Sections Nos. 1 (St. Nazaire) and 2 (Bordeaux), and to the hospital centers at Bazoilles-sur-Meuse, Paris, Tours, and Vittel-Contrereville. A station list issued immediately after the armistice was signed showed that consultants in neuropsychiatry were on duty in the follow-

ing base hospital centers: Allerey, Beaune, Bazoilles, Commercy, Limoges, Mars, Nantes, Paris, Tours, Vichy, and Vittel-Contrexeville. Base Sections Nos. 1 (Savenay) and 2 (Bordeaux) were similarly provided for. Although no officers had been designated general consultants for the following centers, each of them had at least one base hospital to which a neuropsychiatrist was attached: Clermont-Ferrand, Dijon, Langres, Mesves, and Rimaucourt.

At the time of the signing of the armistice, the administration of the professional services, as far as neuropsychiatry was concerned, was on a very effective and satisfactory basis and could have continued so with a very much larger load of responsibility in all activities. There was considerable difficulty in keeping in touch with different officers assigned to this work, but efforts were continually being made to improve methods of communication. It was planned to have conferences during the winter, in which studies could be made of experiences to date and plans could be prepared for the heavy load that was expected when activities were resumed in the spring.

Immediately after the armistice, the medical officer who had served since January, 1918, as division psychiatrist in the 2d Division was assigned to duty as consultant, Base Section No. 3 (Great Britain).

With reference to the neuropsychiatric hospitalization facilities during the period of active hostilities, by February, 1918, we had sixteen base hospitals strung along our lines of communication, either receiving or equipped and ready to receive patients. A typical set-up was that at Bazoilles-sur-Meuse. The personnel consisted of a major, M.C., in charge; a captain who was the ward physician, and a 1st lieutenant assisting, three sergeants with supervising, mess, and office duties; eight female nurses; and seventeen enlisted men working as ward attendants, doing kitchen duty, and so forth.

Base hospital No. 117 at La Fauche was a treatment center for war neuroses and for scientific work. Soon after its establishment its capacity was increased to 1,000. The staff was much overworked but "carried on" splendidly. The La Fauche record was an enviable one: 3,208 admissions; 50 per cent returned to combat duty; 41 per cent to other duty in the A. E. F. Psychotic casualties were received at base hospital No. 8 at Savenay near St. Nazaire, for a time at No. 66, and subsequently at the Bazoilles center.

In addition there were three army neurological hospitals serving the

First Army, and one serving the Second Army. Hospital No. I of the First Army, at Benoite Vaux, received a considerable number of acute cases. The factor of exhaustion was marked, but after this was relieved there was a prominent psychoneurotic clinical display. Under the influence of food, rest, and very simple psychotherapy, 60 per cent of the soldiers were returned to duty in less than two weeks.

From this hospital 65 instances of "concussion neuroses" were reported, but only 10 cases of actual concussion. In view of the fact that now probably the most moot question of war psychiatry is the determination of better criteria of differentiation between traumatic, organic brain injury and psychoneurosis, it is likely that twenty-five years ago the margin of error was considerable.

Neurological hospital No. II at Toul received only a few casualties.

No. III near Souilly at Nubecourt had a small but very active service including acute war psychoses. They seemed to fall into three groups. In the first group there was a striking inability to fix the attention; the second group showed a pattern of confused delirium; in the third group catatonic stupor was prominent. Some of the reactions were very similar to those seen recently in the marines who were in the worst of the fighting at Guadalcanal.

The army neurological hospital of the Second Army was located at Varvinay, about seven and one-half miles from the battle line. Since military operations of the Second Army ended with the signing of the armistice on November 11th, just a few days after the Second Army had begun to fight, the activities of this hospital were likewise brief. The total number of admissions amounted to 12, and these were admitted on November 9. Of this number, 9 were returned to duty and 3 evacuated to Base Hospital No. 117. All of these cases came from the 33d Division, which was operating to the north of Varvinay. The hospital was closed on November 23, 1918.

Liaison with the division of neurology and psychiatry in the Surgeon General's Office was maintained by personal communication in the form of letters and cables between the chief of the division of neurology and psychiatry, in the Surgeon General's Office, and the consultant in neuropsychiatry, A. E. F. This informal method was first approved by the chief surgeon, but the restriction of censorship was a formidable barrier.

One of the most valuable aids which the neuropsychiatric work in France obtained during the war came through the visit made by the

chief of the division of neurology and psychiatry in the Surgeon General's Office. The medical officer concerned visited England first and spent July, August, and part of September in the American Expeditionary Forces. He was able to visit the French neuropsychiatric hospitals and training centers which the senior consultant in neuropsychiatry, A. E. F., had been unable to see because of great pressure of work.

The visit of the chief of the division of neurology and psychiatry yielded the following suggestions for the A. E. F.

Everything seems to point to our soldiers developing neuroses to a degree even greater than has occurred among the British, unless special means are taken to prevent. The conditions of American life having been such that a young man suddenly taken from surroundings where he more or less always had his own way, where obedience was never necessary, where he was taught that he was the equal of everyone, suddenly taken from surroundings of that character and forced to obedience, forced also to face all this war has of horror, it would not be surprising if he showed his reaction to the change by developing a neurosis if he were given a chance. French neurologists with whom I have talked have spoken of the excessive nervousness of American soldiers who have been under their care.

It would seem then that we should profit as far as we can from the experience of the French in this matter. Check the development of neurosis by denying its existence at the start. Each army should have its own center of a capacity of at least one and a half beds to each 1,000 troops. It should keep its patients two or three weeks if necessary, and should be entirely independent of any hospital of the communication or base.

The treatment of the patients should be calmativ and restorative and any appearance of such symptoms as tremors, paralysis, etc., should be rigidly discouraged. This idea should run through the whole personnel of the hospital. At first it should be effected by gentle persuasion but, if the patients persist in the production of hysterical symptoms, sterner measures should be resorted to. It is not considered desirable to send patients of this class to convalescent camps. It would be better for them to have leaves, and the threat to cut off the leave might persuade many to suppress the self-indulgence which is so often the neurosis and give up their symptoms. Isolation and strong faradization might also be employed with advantage at this stage.

Those patients should be held at the army hospital with the greatest tenacity. The chances of their permanent military recovery are reduced the moment they are sent back. It is strongly recommended that none of this class be returned to America until after the war. The influence of the home country would make it extremely difficult to organize a hospital service where these cases could be properly treated, and there would be small hope of ever fitting the patients again for military duty. And the fitting for military duty is the one means of effecting a satisfactory cure. A neurosis which has lasted for a

year or more has established a habit which persists, or is prone to persist, after the cause is removed. This is shown by the numbers of permanently (or apparently permanently) disabled men today, discharged from the army in England and Canada

As has been mentioned, psychiatrists participated very extensively in the deliberations of disability boards, and the impress of enlightened psychiatry could be traced in many of their findings. The general principles governing the question of "in line of duty" or "not in line of duty" are worth restating.

I. In accordance with verbal request, the general principle governing this disability board, with respect to line of duty in nervous and mental diseases, is submitted.

The following cases are considered not in line of duty:

1. Psychosis in men who have had a well-established psychosis previous to enlistment.
2. Psychosis in men so psychopathic in constitution that the psychosis represents merely an episode in a constitutionally psychopathic individual.
3. Psychoneuroses which were well established before enlistment and did not arise as the result of military service.
4. Epilepsy in men who have had well-established epilepsy previous to enlistment.
5. Mental deficiency.
6. Constitutional psychopathic states in men who have a life history of associated alcoholism, criminal tendencies, and delinquencies.

II Cases considered in line of duty:

1. All psychoses developing since enlistment, presumably as the result of military service, without established histories of previous attacks.
2. Epilepsy, with first history of well-established epileptic seizures occurring since enlistment and presumably as the result of military service, such as traumatic cases, shock, and others.
3. Psychoneuroses (hysterical states, neurasthenia, anxiety states, and others) in which the condition developed since enlistment, presumably as the result of military service.
4. Other diseases of the nervous system—such conditions as toxic neuritis, traumatic cases, affecting the nervous system—are considered in line of duty, unless well-established histories indicate their presence previous to enlistment.

III. In a number of cases of syphilis of the central nervous system the board has had difficulty in deciding the question of line of duty. These are cases in which the time of the initial infection is unknown and in which the invasion of the central nervous system occurred since enlistment and where military

service may have been an important etiological factor. Instruction is desired as to proper procedure in such cases.

IV. The above general principles are followed and applied to each individual case, in accordance with the history as established. In acute psychoses the cases are considered in line of duty when the history of a previous attack can not be established.

An honest recounting must record not only the wise steps that were taken but also the mistakes that were made. The Reclassification and Efficiency Board at Blois was a rather dark spot in medico-military history. Officers who had failed to "make good" were demoted and otherwise "disgraced." There were quite a number of suicides. There should have been a larger leavening of psychiatry. It was also a mistake not to return psychotic patients to the United States in separate boats. And it was an error to have so few female psychiatric nurses with the A. E. F.—sixty-six in all.

For the army of occupation adequate neuropsychiatric provisions were made. The officers and men of the Third Army were battle-tested veterans, but the war was over; accumulation of fatigue made itself felt; there was the anticlimax at the end of prolonged emotional stress. Admittedly, it was an honor to be in the army of occupation, but other soldiers were on the way home. Altogether it seemed wise to organize a suitable neuropsychiatric service.

At first, field hospitals were made to serve but as soon as the troops began to arrive in numbers two neuropsychiatric hospital units were opened, unit No. I with 40 beds at Coblenz, and unit No. II with 57 beds at Trier, these numbers on the basis of one bed to every 2,500 soldiers.

The following table gives an idea of the distribution of diseases among the 1,286 patients received at the centers of Coblenz and Trier.

Psychopathic cases:

Mental deficiency and psychoses	566
Psychoneuroses	263
Epilepsy	65
Alcoholism and drug addiction	69
Psychiatric conditions not involving definite disorders	59
Total	1,022

Neurological cases:

Cerebrospinal syphilis (exclusive of general paresis)	25
Paralysis	33
Neuritis	38
Neuralgia	27
Brain Tumor	4
Miscellaneous neurological and internal medical conditions	137
Total	264

The largest proportion of patients with mental deficiency and constitutional psychopathic states came to the hospital in February and March, due to the efforts referred to above to eliminate unsuitable men. Had many of these men not been evacuated through other channels, the admissions at Coblenz and Trier would have been considerably higher. It is noteworthy that during a period of seven months a military population which averaged approximately 200,000 officers and men contributed 5 psychopathic patients and 1.5 neurological patients per 1,000 strength.

The results obtained with many of the cases treated were excellent. Although the number returned to duty was small, this was because it seemed expedient, even after recovery—especially in the case of the lighter depressions—not to return a soldier to duty again. Such cases were almost invariably sent to France to be returned to the United States. In many cases the course of the disease was very favorably influenced by the possibility of early treatment. It is doubtful whether mental cases in any similar population have ever been received so quickly and with so little legal or administrative formality as they were in the neuropsychiatric units of the army of occupation.

The number of suicides that occurred in the army of occupation was very small. Not one of these occurred in a patient who was under observation for mental disorders or in the wards at neuropsychiatric centers. This result is significant, because of the fact that at all times, among these patients and in the wards, states of depression were more frequently seen than any other psychotic manifestations.

Thus, along with World War I its psychiatry passed through the portals of history to await history's judgment. More than a quarter of a century later that judgment on the whole is favorable. There were some brilliant strokes of psychiatric genius; there was much more day-in and day-out

hard psychiatric work rather well done; there were many small mistakes; there were a few serious errors. To those of us who served, the memory of World War I is a memory of noble proportions—the memory of Thomas W. Salmon, executive psychiatrist, humanitarian, a skilled, kindly, and gallant leader.

Perhaps a comparison should not be made between the psychiatry of World War I and that of World War II. However, in my opinion the overall psychiatry of the first war was definitely in advance of the psychiatry of this war, at a cross-section taken twenty months after the opening of hostilities. There was a relatively larger psychiatric personnel, but then it was easier to find psychiatrists for 3,500,000 than it is for 10,000,000. This war is more an air and sea war than was World War I. The aviation phase has introduced new problems. In the first war the Navy had only a relatively small psychiatric problem; in this war it has a much larger one, which is being handled effectively.

World War I taught many valuable psychiatric lessons. It is sad to relate that they were almost totally forgotten. That must never happen again. Irrespective of whether our armed services in the future are to be small or large, the experiences of military neuropsychiatry must not be preserved in inaccessible archives but must be given constant and energetic application.



THOMAS W. SALMON

ALBERT DEUTSCH

III. MILITARY PSYCHIATRY: WORLD WAR II

1941-1943

MILITARY psychiatry has been the subject of widespread and often bitter debate from the onset of the war emergency up to the time of this writing (October, 1943). Only the end of this war, plus a reasonable period of calm but searching reflection in retrospect, can bring a final solution to the many questions of military psychiatry which were still being debated at the moment the Anglo-American troops were pushing from Naples up to Rome and the Russians were breaking the vaunted Dnieper line. At this juncture it is possible only to describe a few major aspects of the significant role of American psychiatry in World War II.

The utilization of psychiatry in the war has centered around five main objectives:

1. The selection of mentally fit recruits for the armed forces.
2. The detection and separation, at the earliest possible time, of bad military risks, from a psychiatric point of view, who had somehow slipped past the draft and induction-station medical examiners.
3. Prompt and effective treatment of psychiatric casualties, in both training camps and combat areas.
4. Plans for rehabilitation of psychiatric casualties upon their return to civilian life.
5. The maintenance of mental health and the furtherance of good morale among men in the armed forces.

The mobilization of psychiatric resources toward these ends proceeded with but slow, faltering steps during the early part of the war emergency. It had seemed certain to many observers that the lessons of World War I in the recruitment of military manpower would preclude a repetition of the costly delays and blunders of 1917. These observers were doomed to disappointment by the sequence of events following the onset of the war. Nearly all the lessons of the first World War, so poignantly reflected in General Pershing's cabled plea from France in 1918 for more careful psychiatric screening, had to be relearned.

Long before Pearl Harbor there were psychiatrists who foresaw the inevitable entrance of the United States into the war, and who sounded the clarion for all-out psychiatric preparation. Among the first groups to

act was the William Alanson White Psychiatric Foundation, created as a memorial to one of America's greatest psychiatrists. As early as 1938, the trustees of the Foundation had prepared a preliminary memorandum on the place of psychiatry in the armed forces.

In the February, 1939 issue of its journal, *Psychiatry*, the Foundation published a report of one of its trustees, Capt. Dallas G. Sutton, United States Navy Medical Corps, on "The Utilization of Psychiatry in the Armed Forces." Pointing out that there was very little psychiatric screening in peacetime recruitment procedures, Captain Sutton stressed the importance of eliminating the mentally unsuitable in the anticipated creation of a huge military force.

An editorial in the same issue of *Psychiatry*, entitled "Psychiatry and the National Defense," appealed for a full mobilization of psychiatric resources to help meet the widening international upheaval then threatening democracy.¹

At its annual meeting in May, 1939, the Council of the American Psychiatric Association took cognizance of the oncoming crisis by authorizing the president of the Association to appoint a Committee on Military Mobilization which would confer with the Federal authorities on the utilization of psychiatric personnel. Dr. Harry A. Steckel was made chairman of this committee; a survey of available personnel was undertaken. In other respects, however, the committee's efforts were very modest.

It must be said, in truth, that the steps taken by the Association to give leadership and direction to the psychiatric aspects of military mobilization were at first marked by hesitation and uncertainty of purpose. While other professional bodies quickly and firmly assumed leadership in the formulation of program and policy leading to the integration of their special fields into the national war program, the American Psychiatric Association seemed content to offer its services to the appropriate authorities and patiently wait to be called. It displayed a remarkable tolerance toward inaction, unconscionable delay, and occasional fumbling on the part of officials responsible for utilizing psychiatric skills and procedures. When, in 1942, it finally became aroused to the point of official protest, much damage had already been done by the neglect of readily available psychiatric knowledge and personnel in the selection and training of military manpower.

The Southern Psychiatric Association, at its annual meeting held in

¹ *Psychiatry*, II (1939), 1-9; 133-135.

Louisville, Kentucky, in October 1939—barely a month after the Nazis invaded Poland—acted with commendable foresight. It unanimously adopted a resolution memorializing the Federal Government on the important role of psychiatry in the national emergency. Simultaneously, the Southern Psychiatric appointed a committee of three to prepare a report on the place of psychiatry in the national emergency. The committee turned in a report at the next annual meeting of the Association, held October 21, 1940. The report acknowledged the challenge to psychiatry and outlined the main lines of its responsibility in the selection and training of men for the armed forces and the maintenance of civilian morale. It dealt in large part with the Selective Service Act, which had been passed by Congress in September, 1940, and had gone into effect on October 16. Optimism over the projected role of psychiatry was expressed in the report, wherein it was stated: "The Selective Service System seems to be fully awake to the importance of psychiatric considerations in connection with securing candidates suitable for training."² This note of optimism indeed seemed firmly grounded in fact at the time, however false it was to prove subsequently.

The National Research Council, which enjoyed quasi-public status, early created a subcommittee on neuropsychiatry to study and report on psychiatric aspects of the war emergency. This subcommittee was headed by Dr. Winfred Overholser, superintendent of St. Elizabeths Hospital in Washington, D. C. Dr. Overholser, whose location in the national capital gave him easy access to Federal agencies and officials, played an active role in subsequent planning related to military psychiatry.

The William Alanson White Psychiatric Foundation, alert to the significance of the war emergency, had set up, as early as October, 1939, a standing committee of psychiatrists "to proceed with the formulation and execution of certain measures looking to the more effective utilization of psychiatry in the national defense." In June, 1940, the Foundation created a committee of trustees to observe psychiatric procedures in Great Britain in connection with the war, but the project had to be abandoned because of strict State Department interpretation of the existing Neutrality Act's prohibition against United States citizens' sailing to foreign ports within the proscribed war zone.

The Foundation committee then prepared a plan for the psychiatric

² "Psychiatry and the National Defense; Report of a Committee of the Southern Psychiatric Association," *Psychiatry*, III (1940), 619-624

examination of draft registrants. This was printed in October, 1940, and became the basis of the famous Medical Circular No. 1, promulgated by the Selective Service System on November 7th of the same year.³

The purpose of the circular, entitled "Minimum Psychiatric Inspection," was to afford a primer that would help the physicians attached to the 6,403 local draft boards to detect disabling mental and personality factors in draft registrants. As subsequently revised, the circular divided neuropsychiatric handicaps into eight broad categories, and briefly described each. Included in these eight groups were: mental defect or deficiency; psychopathic personalities; major abnormalities of mood; psychoneurotic disorders, grave mental and personality handicaps (pre-psychotic and postpsychotic personalities, and the like); chronic inebriety; syphilis of the nervous system, and active organic disease of the brain, spinal cord, or peripheral nerves.⁴

As set up at the time, the Selective Service medical examinations of draft registrants consisted of a double screening process. Voluntary medical examiners attached to each local board provided a coarse screening for selectees, sifting out those who were obviously unsuitable for military service by reason of mental or physical defect. Doubtful cases were referred to the Medical Advisory Board, a central group of specialists serving a number of local boards. There were 584 of these Medical Advisory Boards throughout the country, each with a psychiatrist on it.

Men who showed no gross mental or physical disability, and who were qualified for military service in other respects, were sent on to an army induction center. Here the final physical and psychiatric screening took place. (The navy, until 1943, remained outside the Selective Service System, accepting only volunteers and examining them at its own induction stations. On February 1, 1943, Selective Service began to process draft registrants for the navy as well as the army.)

The Selective Service System's Medical Circular No. 1 was supplemented in March, 1941, by Circular No. 19 from the Surgeon General's Office, "Neuropsychiatric Examination of Applicants for Voluntary Enlistment and Selectees for Induction." This circular was intended to supply medical examiners at induction centers with the same type of psychiatric information as had been presented to physicians attached to local draft boards.

³ "National Security" (an editorial), *Psychiatry*, IV (1941), 442.

⁴ "Minimum Psychiatric Inspection—Medical Circular No. 1 (Revised)," *J Am Med Assn*, CXVI (May 3, 1941), 2059-2060.

The circular letter concluded with a hard-hitting admonition to draft board officials who were sending obviously unsuitable registrants to the induction stations on the theory that "the Army will make men of them."

The Army [the letter stated] is one of the elements of national defense, and its present mission is one of preparation for an offensive-defensive type of warfare. It is in no sense a social service or a curative agency. It is to be considered neither a haven of rest for wanderers nor a corrective school for misfits, ne'er-do-wells, feeble-minded persons or chronic offenders. Furthermore, it is neither a gymnasium for the training and development of the undernourished or undeveloped nor a psychiatric clinic for proper adjustment to adult emotional development. Therefore, there is no place within the Army for physical or mental weaklings, potentially psychotic or prepsychotic persons or those with behavior problems. Men who present behavior problems in the civilian community will certainly present intensified problems in the service.

These two circulars made it appear very probable that adequate psychiatric safeguards would be established in the military mobilization program. Indeed, Dr. Clarence A. Dykstra, first director of the Selective Service System, showed a most sympathetic attitude toward psychiatrists who offered their cooperation, individually and collectively. He had accepted the memorandum of the William Alanson White Psychiatric Foundation as the basis for Medical Circular No. 1, and had appointed Dr. Harry Stack Sullivan, then president of the Foundation, as his psychiatric consultant. The Surgeon General's Office in the War Department also manifested a satisfying appreciation of psychiatric screening at this time. As early as October 30, 1940, the Surgeon General sent a directive to Corps Area Commanders ordering that neuropsychiatric examinations by induction boards should, whenever practicable, have one neuropsychiatric examiner for each fifty registrants examined daily.⁵

This directive was greeted as a significant step by psychiatrists who had warned against decide-at-a-glance, shotgun decisions on the mental status of selectees. The consensus of opinion among interested psychiatrists was that a minimum of fifteen to twenty minutes per man was needed for an adequate psychiatric examination. The Surgeon General's directive came as close to this desideratum as they dared hope.

Another favorable development was the launching, in January, 1941, of a series of seminars for psychiatrists on medical advisory and army induction boards. Teams of outstanding military and civilian psychiatrists, together with Selective Service officials, held two-day seminars in

⁵ *Psychiatry*, IV (1941), 443.

a number of key American cities, giving orientation to medical examiners of the respective areas.

But the task of educating the local examiners proved most difficult. Directives from Washington were widely ignored. As the war crisis grew deeper confusion over plans arose at central headquarters. The casual pace of military mobilization had to be stepped up with increasing speed. The changing tempo left many fine plans in limbo.

Too many good ideas were accepted only in theory; sufficient pressure to put them into practice was not forthcoming either from within or without the Selective Service System and the army. Plans for incorporating sound psychiatric procedures in the draft process were held in abeyance. When the fateful occurrences at Pearl Harbor, December 7, 1941, aroused the Nation to a frenzied demand for a huge military force, with the accent on quantity rather than quality, the carefully developed plans for adequate psychiatric screening were tossed overboard, along with corresponding standards for physical selection.

At the very outset of the "national defense" emergency, impressive statistics were presented to the public showing the high economic and social cost of psychiatric casualties in World War I. These figures usually accompanied warnings that similar ill effects might recur unless proper safeguards for the psychiatric screening of military personnel were immediately set up.⁶ The statistics showed, for example, that:

The U. S. Government, during the period from 1923 to 1940, had paid out nearly one billion dollars for the care, treatment, and upkeep of World War I veterans with service-connected psychiatric disabilities. Nearly \$42,000,000 was spent for this purpose in 1940 alone.

Three out of every five beds in the seventy-nine Veterans Administration Hospitals were occupied by patients with nervous or mental disorders.

Every psychiatric casualty of World War I had cost American taxpayers over \$30,000.

But these impressive facts failed to move responsible officials into prompt and effective action. There were, to be sure, natural obstacles to satisfactory utilization of psychiatric skills and procedures. One—a most important one—was the acute shortage of trained psychiatrists. When

⁶ Dr. Martin Cooley of the Veterans Administration presented many valuable data on the psychiatric toll of World War I. See, for example, his paper on "The Economic Aspect of Psychiatric Examination of Registrants," *War Medicine*, I (1941), 372-382.

the war broke out, there were fewer than 3,500 trained psychiatrists in the entire country—hardly enough to meet military and civilian requirements. Some of the standards set up by psychiatric experts for selecting and training military recruits were impossible of attainment when the need for rapid mobilization of a mass army conflicted with the shortage of available psychiatrists.

A marked coolness toward psychiatric advice and assistance began to be manifested in certain high Selective Service and army circles, even before Pearl Harbor necessitated a rapid acceleration of the draft process and a sharp lowering of medical standards for recruits. Differences arose between Brigadier General (later Major General) Lewis B. Hershey, who had succeeded Dr. Dykstra as Selective Service director, and Dr. Harry Stack Sullivan, his psychiatric consultant.

Dr. Sullivan had thrown himself into his task with tremendous energy and enthusiasm. In concert with his colleagues, he had charted plans for psychiatric aids in the selection and training of military personnel. With dogged perseverance, he insisted that these plans be adopted. The responsible authorities couldn't adopt some which appeared impractical; they wouldn't adopt others which were sound. After a number of rebuffs, Dr. Sullivan finally resigned his post, retiring to the position of an outside critic of the system and its heads. Dr. Raymond W. Waggoner was appointed psychiatric consultant to the Selective Service System in the fall of 1943.

In January, 1942 the double-screening process of selecting draft registrants was abandoned in favor of a single medical examination, to be held at army induction centers under army supervision. The local medical examining boards were virtually eliminated as agencies of coarse screening. This drastic change brought dismay to some psychiatric leaders; they felt that double-screening afforded a better means of detecting psychiatrically unsuitable selectees.

The adoption of the single-screen procedure gave impetus to a movement for fuller inclusion of social histories in determining a recruit's mental status. According to Selective Service standards, residence in a mental hospital automatically disqualified a candidate from military service. It was found, however, that a sizeable number of registrants with records as mental hospital patients were being passed into the army because of neglect of personal histories.

The two-minute average psychiatric interview at induction centers,

unaided by social histories, proved little more than a farce. In some centers as many as two hundred men were examined by a single psychiatrist daily. Under such circumstances psychiatric screening was bound to be a hit-or-miss affair in which the hapless psychiatrist had to spice his knowledge and experience with large sprinklings of hunches and fortune-telling.

Reliable studies showed that increasing numbers of men with mental hospital records were being inducted, only to break down in military service. Preliminary reports indicated that as many as 50 per cent of psychiatric casualties among soldiers could have been prevented at the point of induction had the social histories of these men been available to medical examiners.

At St. Elizabeths Hospital Dr. Alexander Simon and Miss Margaret Hagan, senior medical officer and American Red Cross field director, respectively, found that of four hundred soldiers, sailors, and coast guardsmen admitted to that institution as psychiatric cases, one out of every four had been hospitalized or otherwise treated for mental disorder prior to induction. One third of the men had records of psychosis in the family.

One man, a thirty-year old draftee inducted in 1941, was hospitalized as a psychotic five weeks after induction. Subsequent study revealed that he had been a schizophrenic patient for ten years, had been a resident in four different mental hospitals, and had been let out of the Naval Academy at Annapolis because of a mental breakdown suffered while he was an undergraduate there.

In a paper read before the American Psychiatric Association in 1942, Dr. Simon and Miss Hagan stated that their study indicated that "these men either were not asked or were untruthful concerning a history of previous mental illness. . . . If hospital lists were checked most of these men would have been eliminated merely on this fact alone."

The situation disturbed many psychiatrists on duty at induction centers. Captain David J. Flicker, an Army psychiatrist stationed at Camp Blanding, Florida, put the case bluntly in a paper published in *War Medicine*.

It is my desire to express agreement with [W. C.] Menninger and [E. D.] Greenwood, and those other authors who have stated the belief that the work

⁷ Alexander Simon and Margaret Hagan, "Social Data in Psychiatric Casualties in the Armed Services," a paper read before the Am. Psychiatric Assn., May, 1942 (MSS)

of even a trained neuropsychiatrist becomes largely "hunch," "intuition" and "guess" when his time is too limited . . . It is ridiculous to assume that in two or three minutes it is possible to detect any but the most gross nervous or mental disorders.

How many persons with mild amyotrophies, multiple sclerosis, epilepsy, syphilis of the central nervous system, borderline mentalities, psychoneuroses, constitutional psychopathies, or even major psychoses have slipped by various induction boards is impossible even to guess. A conservative estimate would still be in the tens of thousands, but it is not presumption that many millions of dollars will be spent by American taxpayers for compensation and hospitalization for conditions existing at the time of induction which will not be apprehended until after they become apparent "line of duty" disease. . I feel that not over 25 per cent of those selectees who will break down with psychiatric disorders are being apprehended^a

The increasing insistence on social histories in an evaluation of the mental status of selectees occasionally drew some response from the authorities. A special directive from Selective Service headquarters, dated December 15, 1941, and sent to all local boards, stated that examining physicians knowing or learning of a history of mental disease or poor social adjustment in a registrant should seek and review information from local social agencies, school systems, and state hospitals bearing on the registrant's personal and social background. This directive was for the most part ignored, however. A major reason for its failure was the fact that it omitted provision for the financial costs of obtaining the requisite records.

In some places, as in New York City, psychiatric, mental hygiene, and social agencies united behind proposals to utilize social workers in obtaining the social histories of selectees for draft boards. But these efforts were for the most part frustrated because of lack of funds and/or lack of sufficient interest on the part of key Selective Service officials. In some states—notably Maryland, Connecticut, and New York—Selective Service officials early adopted a routine checkup of mental hospital and other pertinent records of Class IA registrants. But such records were ignored in most states.

The failure to assemble social histories was made the chief point of criticism in a widely publicized memorandum on "the role of psychiatry in the selective process," drafted jointly in 1942 by the New York City Mental Hygiene Committee and the Emergency Committee of Neuro-

^a David J. Flicker, "Psychiatric Induction Examination," *War Medicine*, II (1942), 935-936

psychiatric Societies of New York City. This memorandum, printed as a twenty-five-page pamphlet, reviewed the psychiatric history of World War I, described defects in the selective process and in army medical organization, and proposed remedies.

"The most serious defect of the present method of enrolling men in the services," it stated, "is that it makes it impossible to assemble a personal and medical history. As long as this condition obtains, the processes of medical and psychiatric selection will remain tragically inadequate with respect to organic, psychiatric and psychosomatic disabilities."⁹

The National Committee for Mental Hygiene was active in the movement to have social histories incorporated in the selective process. Early in 1943, the Committee employed Dr. Luther E. Woodward, on leave from the New York City Education Department's child guidance bureau, on a full-time basis in an unofficial liaison capacity with the Selective Service System. Dr. Woodward's duty consisted chiefly of organizing methods of history-taking in various state and local selective service agencies. His efforts were considerably handicapped by Federal reluctance to provide the necessary funds.

Finally, in October, 1943, the Selective Service System announced a nation-wide program for utilizing volunteer social workers in gathering personal and medical histories of selectees in Class IA. By that time, some seven or eight million men had already gone through the draft process into the armed forces. Only a fraction of that number were then needed to bring the military forces up to full strength. However, even this belated gesture toward more adequate psychiatric screening was hailed by most experts, on the "better-late-than-never" principle.

In the spring of 1942 the neglect of psychiatric safeguards in selecting and training recruits had reached such grave proportions that the Council of the American Psychiatric Association, at its annual meeting in Boston, adopted a resolution stating:

Once again we are confronted with a national emergency. The country is participating in a world struggle of incalculable forces. It is most alarming to note that the Naval and Army forces are not utilizing the psychiatric facilities of this nation to the fullest extent. These facilities, both for actual military

⁹ *A Memorandum on the Selective Process in General and on the Role of Psychiatry in the Selective Process and in the Armed Forces* (New York, Mental Hygiene Committee, August, 1942). The committee which drafted the memorandum consisted of Drs. Richard M. Brickner, Lawrence M. Kubie, Lawson G. Lowrey, John A. P. Millet, George S. Stevenson, and Miss Marian McBee.

purposes and for civilian or military morale, are being shockingly unappreciated in spite of the lessons learned from the last World War.

The resolution authorized the president of the Association to appoint "a well-chosen committee with power to act in making forceful representation of this status of affairs." Accordingly, Drs. Arthur H. Ruggles, Edward A. Strecker, and Frederick W. Parsons were appointed to this committee.¹⁰

One of the chief problems leading to the creation of the committee was the evident neglect of psychiatry in the army's medical program. No effort had been made to set up a special psychiatric section in the Army Medical Corps, the necessity for which had been plainly indicated by the events of World War I. What was particularly shocking was the flagrant waste of psychiatric manpower in the face of an acute shortage of trained personnel. Instances piled up where psychiatrists entering the Army Medical Corps were used in a general capacity, while other army doctors who had been general practitioners were put in charge of psychiatric wards in military hospitals.

If certain high officials stubbornly turned a deaf ear to the warnings sounded by alert individuals and groups on the consequences of neglect of psychiatric procedures, they could not be indefinitely blind to the impressively mounting lists of psychiatric casualties among military men. As the war progressed, the existing defects in the draft screening process and in the army medical organization became increasingly evident. Pressure for psychiatric reform now came not only from "outside" psychiatric sources suspected of self-interest, but from line officers bedeviled by the disruption of morale and routine arising from psychiatric casualties in the ranks.

A major step toward solving the problem was taken in February, 1942, when the Surgeon General of the United States Army created a Neuropsychiatric Branch in his office. Dr. Roy D. Halloran, superintendent of the Metropolitan State Hospital in Boston, Massachusetts, was named head of the new branch in August, 1942, with the rank of colonel.¹¹ Lt. Col. Malcolm J. Farrell was transferred from the Lovell General Hospital at Fort Devens to serve as Colonel Halloran's assistant.

This step seemed to mark a turning point in the evaluation of military

¹⁰ *Am. J. Psychiatry*, ~~XCIX~~ (1942), 145

¹¹ Col. Halloran died suddenly on November 10, 1943, at the age of forty-nine. He was succeeded by Lt. Col. William C. Menninger, who took office in December, 1943

psychiatry. Thenceforth, army psychiatric organization progressed steadily, if somewhat slowly and belatedly. In response to a suggestion from the American Psychiatric Association's special three-man committee, neuropsychiatric consultants were appointed to several Service Commands. Lt. Col. Franklin G. Ebaugh, Lt. Col. William C. Menninger, Lt. Col. Douglas A. Thom, and Major Garland A. Pace were named consultants to the Eighth, Fourth, Second, and Seventh Service Commands, respectively. It is now expected that divisional psychiatrists will soon be appointed for every army division.

In 1942 a school for training psychiatrists for army service was established at the Lawson General Hospital in Atlanta¹² (the school was later removed to Brentwood, New York). Directed by Col. William C. Porter, its first classes were opened in January, 1943, with some thirty psychiatrists attending. The main object of the school's four-week course was to orient psychiatrists—entering army service from varied civilian backgrounds and representing widely differing schools of theory and practice—in the specific needs of military psychiatry.¹³

Early in 1943, Lt. John W. Appel was installed in Colonel Halloran's office as liaison officer between the Neuropsychiatric Branch and the Army's Special Service Division, under Brigadier General Frederick Osborn, in order to bring psychiatric and morale services into more intimate relationship.

Meanwhile, in September, 1942, Dr. Arthur H. Ruggles, then president of the American Psychiatric Association, was appointed by Secretary of War Stimson to serve on a medical committee to study the health of the army. This committee made a thorough study of army medical problems, including mental health, and rendered a confidential report to the Secretary which resulted in several important reforms. Later Dr. Ruggles was named to a special committee of civilian psychiatric advisors to study and report to Surgeon General Norman T. Kirk (who had succeeded Gen. James C. Magee) on problems of neuropsychiatric rejections and discharges in the army. Other members of this committee included Drs. Winfred Overholser (chairman), Karl M. Bowman, Titus Harris, Edward A. Strecker, and Frederick W. Parsons.

In the spring of 1943 Dr. Strecker, 1943–44 president of the American Psychiatric Association, had the unique distinction of being named psy-

¹² William C. Porter, "The School of Military Neuropsychiatry," *Am J Psychiatry*, C (1943), 25–27.

chiatric consultant to the Secretary of War for the Army Air Forces, and also to Surgeon General Ross T. McIntire for the navy.

A psychiatric debate that evoked much public interest was stirred up in the fall of 1942 by a bill then pending in Congress to lower the minimum draft age from twenty years to eighteen, thus broadening the military manpower pool. When the bill was first introduced, a group of psychiatrists and educators formed a committee to seek its defeat, on the ground that youths of eighteen and nineteen years of age were emotionally too immature to be drafted for military service. This group, calling itself the Committee on Drafting Youth, opposed the "teen-age draft" in letters to newspapers and in testimony at Congressional hearings.

Concerned with the possible effect on national morale of the statements issued by this committee, another group of psychiatrists hastily drew up a public statement upholding the "teen-age draft."¹³ This statement, issued in October, 1942, read in part as follows:

Speaking as individuals, we wish to assure the public and parents of this age group that there are no grounds for apprehension as to the effect of military service on the younger men as distinguished from the older men. Such statistics as are available indicate that the incidence of mental breakdowns is no greater in the 18 and 19 year age group than in the older group.

It would seem to us that the proposal now before the American Congress does not unduly compromise the future mental integrity of this particular age group or of the nation.

The bill including eighteen- and nineteen-year-olds in the draft-age group was enacted shortly afterward. It was the opinion of military authorities, one year after it went into effect, that the teen-age youths reacted to military life as well as older men did.

In May, 1943, the annual meeting of the American Psychiatric Association was featured by a symposium on military psychiatry.¹⁴ Col. Roy D. Halloran and Lt. Col. Malcolm J. Farrell presented a paper reporting a number of significant developments in army neuropsychiatry. Most important of these, perhaps, was the establishment of mental hygiene units at replacement training centers. The first of these had been or-

¹³ The signers of this statement included Drs Adolf Meyer, C Macfie Campbell, Foster Kennedy, C C. Burlingame, Edwin G. Zabriskie, Winfred Overholser, S. Bernard Wortis, Tracy Putnam, and Oskar Diethelm.

¹⁴ The entire July, 1943, issue of the *American Journal of Psychiatry* was devoted to publication of the papers read at this symposium. A special grant from the Josiah Macy, Jr., Foundation made possible an unusually wide distribution of this issue.

ganized at Fort Monmouth, New Jersey, under the direction of Capt. (later Major) Harry L. Freedman.

It is inevitable [Halloran and Farrell observed] that even under the most exacting induction examination, some individuals will be missed who cannot adapt themselves to military life. Every attempt, therefore, must be made to weed them out during the early training period. It soon became evident that the ideal place to accomplish this is in the replacement training center. Here the new soldier is given basic training and here the hazards of Army routine begin to manifest themselves in emotionally unstable and intellectually inadequate individuals. The Army has established, therefore, special mental hygiene units in eighteen replacement training centers, under the direction of specially selected and qualified neuropsychiatrists. More will be established as qualified specialists become available.¹⁵ This medical officer is assisted by a psychologist and a psychiatric social worker furnished by the American Red Cross. In some instances, psychiatric social workers among enlisted personnel are available.

The purpose of these clinics is to aid the adjustment of normal individuals and those with minor difficulties, and to detect and eliminate the mentally unstable who are or may become a distinct liability to military training.¹⁶

The authors also reported that, since January, 1942, rejections for neuropsychiatric causes had varied between 7 and 8 per 100 men examined, as compared with only 2 per 100 in World War I. Rejections on neuropsychiatric grounds had amounted to about one third of the total rejections for all causes.

The hospital admission rate of neuropsychiatric cases in 1942, Halloran and Farrell continued, was about 2.7 per 100 men. Neuropsychiatric cases accounted for about 5.4 per cent of all patients remaining in army hospitals, about one third of all medical discharges from army service, and 15 to 20 per cent of army casualties reaching this country from overseas areas. The actual ratio of neuropsychiatric disorders to all casualties in these areas amounted to about 5 per cent. The authors of the report went on to say:

No new mental disturbance has as yet been described in the present war either from our own experience or from that of our Allies. A glance at the diagnoses lists will readily show that the disturbances encountered are similar to those in civilian life. All of the familiar psychoses are encountered, with

¹⁵ All replacement training centers were subsequently provided with mental hygiene units A. D.

¹⁶ Roy D. Halloran and Malcolm J. Farrell, "The Function of Neuropsychiatry in the Army," *Am J Psychiatry*, C (1943), 14-20

schizophrenia and the affective disorders heading the list while the organic reaction types are relatively few. While the clinical course of many of these psychoses closely parallels those found in civilian life, many military neuropsychiatrists have observed numerous schizophrenic-like manifestations, emotional disturbances, and peculiar personality disorders which appear rapidly, approach a full-blown psychosis which may even defy differentiation from the accepted syndromes, only to dissolve quite rapidly under brief hospitalization.

The psychoneuroses comprise the largest group of mental disturbances in the army, both in the combat areas and in the training areas. The commonest types are, in numerical order, (1) the anxiety states, (2) conversion hysteria; (3) reactive depressions.

As for treatment of neuropsychiatric cases in the army, they pointed to the efforts of the mental hygiene units in replacement training centers as the best examples of preventive and therapeutic psychiatry.

Neuropsychiatric patients, they added, were provided for in special sections of station and general hospitals, where they benefited from the close cooperation between the neuropsychiatric section and other professional sections. Treatment was necessarily along conservative lines. In certain instances, however, the shock therapies were used by specially trained officers, with a view to rendering the patient more adaptable to hospitalization and in some cases preventing the necessity for hospitalization after discharge. Occupational therapy was used in many of the larger hospitals.

One of the grave problems of military psychiatry in World War II was the treatment of the condition erroneously known as "shell shock" in World War I, and variously called "combat fatigue," "conversion hysteria," "exhaustion neurosis," and simply "war neurosis" in this war. Referring to this condition, by implication, Halloran and Farrell observed:

The treatment of the acute neuroses developing in combat zones has been given special attention. All medical officers have been informed that immediate simple treatment can be provided by any medical officer if the afflicted soldier is to be saved for further duty. The British have shown that prolonged rest, induced by sedative drugs if necessary, and good food and reassurance given near the front, will return to duty an estimated 70 to 80 per cent of these acute combat neuroses. This experience has already been confirmed in our own troops.

Most of these conditions can be cared for in the evacuation hospital. Those more resistant to treatment can be evacuated to the rear where they can be cared for by the neuropsychiatrists in station or general hospitals. As in the

last war, experience shows that the further the patient is removed from the situation in which his mental disturbance occurred, the less likely are his chances for salvage for further duty.

A significant step toward the integration of psychiatry in military service was the application, on a limited scale, of psychiatric techniques in building morale among the troops. Reference has already been made to camp mental hygiene units. In some camps, psychiatrists took an active and at times a leading role in morale work. An interesting demonstration of mental hygiene procedures in raising morale and efficiency was described at the 1943 meeting of the American Psychiatric Association by Major R. Robert Cohen of the Ordnance Replacement Training Center, Aberdeen Proving Ground, Maryland.¹⁷ Psychiatrists at the Aberdeen Proving Ground worked out a series of mental hygiene lectures for trainees, explaining the whys and wherefores of army routine. These talks were given to new soldiers during their first few days of basic training. Questions uppermost in the men's minds were frankly discussed—the natural resentment of civilians to army life and regimentation, the problem of fear, and so on. The trainees were invited to discuss their personal problems of adjustment at weekly psychiatric clinics.

This modest system of mental hygiene fortification was tried out under controlled conditions. One company was subjected to the program, while another went without it. By comparing records over a nine-month period, it was found that the companies which had received the mental hygiene talks had considerably more man-hours of training time, less sickness, far less malingering, and greater all-around morale than the other companies.

On the basis of this experiment, the mental hygiene lectures were recorded and filmed, and were used in other training centers throughout the country.

One of the most interesting developments in military morale work was the appearance of a regular column prepared by a psychiatrist in *The Range Finder*, a weekly newspaper at Camp Callan, California. This was a unique venture in the annals of army journalism. The weekly column, entitled "Unconditional Surrender," was written by Major Julius Schreiber, chief psychiatrist of the mental hygiene unit at Camp Callan.

¹⁷ "Mental Hygiene for the Trainee," *Am J Psychiatry*, C (1943), 62-71.

In this column, intended as a morale builder, Major Schreiber discussed in simple language understandable to the average soldier such issues as the basic conflict between democracy and fascism, everyday personal problems of army life, and so forth.

An Army psychiatrist who deals with psychoneurotic soldiers [Major Schreiber explained] finds that many have developed their neurotic disturbances precisely because they have been victimized for months or years prior to their induction by a variety of garbled and distorted notions regarding the issues of the war.

Morale is a state of mind which enables a soldier to carry on and persevere in his mission in spite of the most adverse conditions. It can come only when he fully understands the very fundamental issues at stake—only when he feels that he is an integral part of everything he is fighting for.

Another notable development was the increasing tendency to consult psychiatrists in handling delinquent soldiers. This trend was noted by Halloran and Farrell in their aforementioned paper.

Military law requires proof that the accused intended to commit the crime with which he is charged and also that he had the capacity of intent. This immediately raises the question of mental competency. The Manual for Courts-Martial directly charges the President of the Court and the Trial Judge Advocate with the duty of referring questionable cases for psychiatric study. The neuropsychiatrist, therefore, finds himself more than any officer appearing before courts.

The Army has recognized that many soldiers who are in conflict with military law have a psychopathic background. Psychiatrists have, therefore, been stationed for a long time at the United States disciplinary barracks at Fort Leavenworth, Kansas. Psychiatrists have been assigned, also, to the newly established detention and rehabilitation centers in each service command, where an attempt is made to salvage as many as possible for further service.

As might be expected, several interesting problems of psychiatry arose in the field of aviation medicine. The tremendous expansion of air power—a decisive factor in World War II—brought in its wake the necessity of selecting and training large numbers of men for the special conditions and hazards of modern military aviation. Elaborate psychologic tests were developed for Army Air Force candidates. It took about ten hours for the candidate to complete these tests of his learning, interests, mathematical and coordinative abilities, concentration, and so on.

A psychiatric examination, known as A.R.M.A. (Adaptability Rating for Military Aeronautics), was given each candidate; stress was laid on

his emotional and temperamental stability. The ultimate question in the examiner's mind, in each case, was:

"Will this man stand up under the stress of combat flying?"

Mental hygiene units were set up at the aviation basic training centers, as in the regular army, to afford preventive and corrective psychiatric counsel and treatment to trainees.

A psychiatric phenomenon of special concern which was encountered in aviation medicine was the appearance of a neurotic reaction variously known as "flyer's (or pilot's) fatigue," "flying stress," and, more acceptably, "fatigue-syndrome." Lt. Col. John M. Murray, of the Air Surgeon's Office in Washington, described this neurosis at the symposium on military psychiatry in May, 1943:

This condition in flying personnel arises chiefly as a result of the continuous and long-continued repression and suppression of the normal fear reactions present in all types of operational flying. In a certain number of flyers, sooner or later the ability to master this conflict fails and the individual breaks out into acute anxiety and/or symptom formation. Numerous other factors contribute to this reaction, such as physiologic fatigue, anoxia, decompression reactions, loss of sleep and psychologically traumatic experiences.

The types of symptoms seen in this group are largely the hysterical and anxiety reactions, psychosomatic disorders, minor depressive swings, and mild hypochondriacal concerns. Outstanding is the patient's complete loss of zest in flying—and sometimes even the desire to fly at all. Characteristic is the nature of the patient's dream life. The flyer is nightly troubled by dreams of flying, accompanied by terror-laden situations and long continuous frustrating experiences, all of which leave him worn out in the morning and completely unfit for his arduous duties¹⁸

Treatment of "flyer's fatigue" or "fatigue-syndrome," as described by Colonel Murray, involved early recognition of the condition and a stay at a rest camp "far enough away from the scene of operations to be free from the tension and danger in an operational area, yet not so far distant as to make the flyer feel he has been evacuated because he has cracked. The flyer must likewise be kept among the men of his own corps."

This same syndrome found in navy flying personnel was diagnosed simply as "fatigue," with the explanatory adjective "combat" or "operational" added to specify the general type.

Those attending the American Psychiatric Association's 99th Annual Meeting in May, 1943, were stirred by two remarkably dramatic papers

¹⁸ "Psychiatry in the Army Air Forces," *Am J Psychiatry*, C (1943), 21-24.

read by navy psychiatrists. Both described combat neuroses among marines and sailors participating in the action on and around Guadalcanal, following the invasion of that South Pacific island on August 7, 1942, which culminated in our first great victory over the Japanese.

Lt. Commander E. Rogers Smith of the U. S. Naval Hospital at Mare Island, California, described the composite story narrated by a group of psychoneurotic patients received at the Hospital from Guadalcanal as "a picture of physical and mental strain that combines the best of Edgar Allen Poe and Buck Rogers." He continued:

One cannot help but believe that the enemy made a careful study of our psychology and our ways of thinking and living and used this knowledge against us in this campaign. Most of us consider the night as a time for rest and sleep, but the Japs centered their activities during this period. They were taught a few American words or phrases, chiefly threatening or profane, and they filled the dark hours with this abuse. They were Machiavellian in their cleverly timed bombings and raids. Sleep was impossible or negligible. No one can sleep when every hour brings the sound of dive bombers or the crash of shells.

Even with the possibility of dietary regularity, digestion is not enhanced by raiding parties or too neighborly bombs. All of these men lost weight and they were not pudgy when they landed on the beach. Weight losses in muscular, toughened young adults ran as high as 45 pounds. Rain, heat, insects, dysentery, malaria, all contributed—but the end result was not blood stream infection or gastro-intestinal disease but a disturbance of the whole organism—a disorder of thinking and living—of even wanting to live. And this incredible strain lasted not one or two days or nights but persisted for months. This was not the quickly terminated but terrific rape of Pearl Harbor nor the similarly acute days of Dunkirk. This was the worst of both of them, prolonged seemingly without end.

The strain and stress experienced by the hardy marines at Guadalcanal, Lt. Commander Smith added, "produced a group neurosis that has not been seen before and may never be seen again."¹⁹

Fear of all kinds entered the picture. Most men experienced fear as they approached the beach. Some tell you of their fear of being afraid and exhilaration as soon as they went into actual combat. But new attacks, new near bomb hits would relight fear—and all this was sure to take some toll. As the weeks passed, hope left most of these men—hope of winning the battle, hope of being aided or rescued. They were alone on this island and their expected relief did not come. They had no way of knowing why it did not arrive. Soon they were sure that none of them would get off the island—they were expend-

¹⁹ In the popular press, this condition was promptly labeled "Guadalcanal nerves."

ible, doomed. Soon this helpless hopelessness overwhelmed them and contributed in no small part to their final collapse.

An astonishing thing about this group of psychoneurotic patients from Guadalcanal, as observed by medical men at the Mare Island Naval Hospital, was the similarity of complaints, symptoms, and objective findings. The men represented all types of physiques, mentalities, emotional environment, and education. Yet, Lt. Commander Smith pointed out, "clinically they were all the same individual, with identical complaints and symptoms." These symptoms included headaches, lowered thresholds to sharp noises, periods of amnesia, of panic, sensory somatic complaints, marked muscular hypertonicity, tremors generalized or limited, and functional palsies. Even after their arrival at the hospital the slightest sharp or sudden noise would cause them to jump or run from the room. Many arrived with cotton-stuffed ears. On the returning transport, many required physical restraint whenever there was test firing.²⁰

Supplementing this paper was one read by Commander Bartholomew W. Hogan, a psychiatrist serving as senior medical officer aboard the aircraft carrier *Wasp* when that gallant ship was torpedoed and sunk off Guadalcanal, while escorting vessels carrying reinforcements to the embattled marines on the island. Commander Hogan presented psychiatric observations on the behavior of the ill-fated ship's crew during and after the torpedoing. His graphic narrative was a portrayal of inspiring bravery, self-sacrifice, and mental stability in the face of a calamitous experience.

The officers and men on the *Wasp* were magnificent. There was never any panic. They courageously fought to save the ship. They risked their lives to help their shipmates, especially the wounded. They all desired to be assigned to carrier duty and get back in the fight.

The *Wasp* had a brief life but a gallant one. . . . It was the *Wasp* that was protecting badly needed marine reinforcements on their way to Guadalcanal when our catastrophe occurred. And in all this, only two minor neuropsychiatric cases developed.

For a number of years [Commander Hogan concluded], I have heard psychiatrists, educators, clergy and others speak of the deterioration of the American youth—born in the drunken, lawless prohibition era of the 'twenties, raised in the depression days of the 'thirties. I tell you that we here should pay tribute to those 18–19–20 year old men who are winning the war and remaining stable.²¹

²⁰ E. Rogers Smith, "Neuroses Resulting from Combat," *Am J Psychiatry*, C (1943), 94–97.

²¹ B. W. Hogan, "Psychiatric Observations of Senior Medical Officer on Board Aircraft Carrier *Wasp* during Action in Combat Areas, at Time of Torpedoing, and Survivors' Reaction," *Am J. Psychiatry*, C (1943), 90–93.

Prolonged applause greeted this apostrophe to the psychiatric toughness of American youth, with the entire audience rising to its feet.

The United States Navy was fortunate in that its Surgeon General, Admiral Ross T. McIntire, showed a strong interest in and appreciation of psychiatry. This interest undoubtedly was a factor in the relatively low incidence of neuropsychiatric disorders among naval personnel from Pearl Harbor to the time of this writing. A neuropsychiatric section was early established in the navy's Bureau of Medicine and Surgery. In May, 1943, Surgeon General McIntire, as has been mentioned, named Dr. Edward A. Strecker as psychiatric consultant to advise him on matters of policy.

Commander Francis J. Braceland, in a review of psychiatry in the navy prepared in April, 1943, pointed out that "psychiatry now has a place in every step of the navy man's career from his induction to his eventual separation from the service."

Psychiatrists [he continued] have been assigned to training stations, hospitals on the mainland, mobile hospitals, air stations, amphibious forces, construction battalions, Marine expeditionary forces, and submarine bases. Young physicians who apply for instruction in psychiatry are being trained at the Naval Medical Center in Bethesda, at the Pennsylvania Hospital and the Graduate School of the University of Pennsylvania in Philadelphia, as well as at St. Elizabeths Hospital in Washington. Indoctrination and refresher courses are in continuous session throughout the year and insofar as can be determined, all men with psychiatric training are being utilized in psychiatric work.

Whenever possible, psychiatrists are present at the Captain's Mast where, in keeping with naval custom, offenders are originally tried. They review the proceedings of courts-martial boards and their advice is sought in all other disciplinary cases including those in naval prisons. From a psychiatric standpoint, disciplinary cases are being handled in a more enlightened manner in the Navy than they are in many of our civilian courts.²²

American knowledge of military psychiatry was greatly enhanced by the Thomas A. Salmon Memorial Lectures delivered by distinguished psychiatrists from abroad in 1941 and 1942. The Salmon lectures for 1941 were presented by Dr. Robert Dick Gillespie, psychiatric specialist with the Royal Air Force in Britain, and dealt with the British experience in wartime military and civilian psychiatry. The 1942 Salmon lecturer was Dr. Emilio Mira, who had been psychiatrist-in-chief for the Loyalist (Republican) Army during the Spanish civil war. Dr. Mira presented

²² Francis J. Braceland, "Psychiatry in the Navy" (MSS)

his observations on military and civilian psychiatry during that conflict, together with a study of psychiatric techniques in the Nazi army. Both Dr. Gillespie's and Dr. Mira's lectures were later published in book form.²⁸

Perhaps the outstanding development, so far, in military psychiatry during World War II is the recognition given to the psychiatric component in certain diseases (peptic ulcer, for instance) which formerly had been treated on a purely physiological basis. Peptic ulcer proved to be one of the most serious ailments in the armed forces.

A series of important studies has appeared in the literature of military medicine on the psychiatric aspects of blast injuries.

Aside from the armed services, the wartime Merchant Marine has constituted a new—or rather an old and heretofore undiscovered—problem for military psychiatrists. The neurosis known in World War I as “shell shock,” and in this war as “combat fatigue,” has affected large numbers of merchant seamen. During the first year of our participation in the war, when the enemy submarine menace was particularly acute, more fatal casualties were recorded among American merchant seamen than among men in both armed services combined.

There were also many psychiatric casualties among the men who faced such harrowing experiences as bombings, torpedoings, long blacked-out voyages through submarine-infested waters, prolonged exposure to cold, hunger, thirst, and exhaustion as survivors adrift on the open sea.

The incidence of “combat fatigue” among survivors of torpedoed and bombed merchant ships created a serious drain on marine manpower. So grave did the problem become that in January, 1943, Surgeon General Thomas Parran of the United States Public Health Service convoked an extraordinary conference of leading military and civilian psychiatrists at the New York Academy of Medicine to discuss ways and means of preventing and treating this condition among merchant mariners. Several prominent psychiatric and public health officials representing Allied nations attended the conference. The meeting gave impetus to the formulation of a program for the treatment and rehabilitation of seamen suffering traumatic neuroses as a result of action at sea. This program, operated jointly by the United States Public Health Service, the War Shipping Administration, and the United Seamen's Service, centered mainly around the need for convalescent homes for survivors of tor-

²⁸ R. D. Gillespie, *Psychological Effects of War on Citizen and Soldier* (New York, Norton, 1942); Emilio Mira, *Psychiatry in War* (New York, Norton, 1943)

pedoed ships. These homes were set up at or near convenient ports of call along the Atlantic, Pacific, and Gulf coasts. Dr. Daniel Blain, a psychiatrist attached to the Public Health Service, was appointed medical director of this treatment and rehabilitation program.

The increasing numbers of military casualties streaming back to this country, together with the progress and intensification of the war, naturally forced consideration of the problem of rehabilitation in civilian life. This broad problem included, of course, the necessity for the adjustment of psychiatric casualties discharged from the armed services.

Unfortunately, the problem of rehabilitation of the mentally sick was largely ignored or insufficiently noticed in the earlier plans for facilitating the adjustment of war casualties to civilian life. This indifference has steadily disappeared, however, in the face of the large proportion of psychiatric cases among the medical disability discharges from the military forces.

Among the agencies and organizations actively participating in plans for rehabilitating psychiatric casualties at this writing are the National Committee for Mental Hygiene and some of its state and local affiliates, the American Red Cross, the Veterans Administration, the War Manpower Commission, and the American Psychiatric Association. There is reason to hope that rehabilitation programs will be far more effective this time than they were in the confused period during and following World War I.

THOMAS VERNER MOORE

A CENTURY OF PSYCHOLOGY IN
ITS RELATIONSHIP
TO AMERICAN PSYCHIATRY

WE might well ask what was the relation between psychology and psychiatry in the year 1844, which saw the birth of what is now termed the American Psychiatric Association. If any student of medicine happened in those days to develop an interest in the diseases of the mind, what books by American authors were available for him to study? Perhaps the first book to which he would have turned was *Medical Inquiries and Observations upon the Diseases of the Mind*, by Benjamin Rush (1745-1813), the fourth edition of which had appeared in 1830. Also available was James Cowles Prichard's *A Treatise on Insanity*, a little volume published in London in 1835 and in Philadelphia in 1837.¹

When we look at the psychiatric works of Rush and Prichard, we see that the authors represent two different points of view in regard to psychology: Rush consulted the works of psychologists for the light they might throw on the disorders of the mind; Prichard disregarded psychology and the philosophers, and concerned himself with a description of the disorders of the mind.

As a matter of fact, the psychology of the day had little to offer, and in his psychiatry Rush made little use of the fundamental psychological concepts with which he prefaced his treatise. He thus outlined his psychology:²

¹ Prichard (1786-1848), like Rush, graduated from Edinburgh. From earliest childhood he was interested in history and languages, and little in Continental European literature was closed to him. His works show him to have been a man of wide education. His theoretical psychology is contained in a *Review of the Doctrine of a Vital Principle* (London, Sherwood, Gilbert, and Piper, 1829). For a memoir of his life, see John Addington Symonds, *Some Account of the Life, Writings and Character of the Late James Cowles Prichard* (Bristol, Evans and Abbott, 1849).

² From the point of view of the relation between psychology and psychiatry, it is well worth mentioning a little treatise by Rufus Wyman entitled, *A Discourse on Mental Philosophy as Connected with Mental Disease* (Boston, Daily Advertiser, 1830). It belongs to the period when psychiatrists turned to philosophy for light on the problems of the mind. Wyman refers to Locke's "immortal *Essay Concerning Human Understanding*" (p. 11) and Dugald Stewart's differentiation between sensory and intellectual perception (p. 13).

³ Benjamin Rush, *Medical Inquiries and Observations upon the Diseases of the Mind* (Philadelphia, Grigg, 1812).

Before I proceed to consider the diseases of the mind, I shall briefly mention its different faculties and operations.

Its faculties are understanding, memory, imagination, passions, the principle of faith, the moral faculty, conscience, and the sense of Deity.

Its principal operations, after sensation, are perception, association, judgment, reasoning and volition. All its subordinate operations, which are known by the names of attention, reflection, contemplation, wit, consciousness, and the like, are nothing but modifications of the five principal operations that have been mentioned.

The faculties of the mind have been called, very happily, *internal senses* . . .

All the operations of the mind are the effects of motions previously excited in the brain, and every idea and thought appears to depend upon a motion peculiar to itself.

Benjamin Rush was personally acquainted with David Hume,⁴ but he seems to have been more influenced by the Scottish school of philosophy with which he came in contact during his medical studies in Edinburgh, from 1766 to 1768. His division of the cognitive mental powers recalls that given by Dugald Stewart in his *Elements of the Philosophy of the Human Mind*, and his "special moral faculty" is in line with Thomas Reid's statement that "If a man had not the faculty given him by God of perceiving certain things in conduct to be right, and others to be wrong, and of perceiving his obligation to do what is right, and not to do what is wrong, he would not be a moral accountable being."⁵

Prichard belongs to the history of British rather than American psychiatry. But at any rate he paid scant attention to psychology in writing his text. When, however, he touched on psychological concepts, he turned to the continental psychiatrists rather than to the philosophers. He mentioned Locke only to criticize him. He rejected Heinroth's classification of mental disorders according to the faculties of the mind and in its place adopted his own classification based on the observed symptoms of mental disorder.

1. *Moral insanity*,⁶ or madness consisting in a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions, and

⁴ Cf. Harry G. Good, *Benjamin Rush and His Services to American Education* (Berne, Ind., Witness Press, 1918), p. 22.

⁵ Thomas Reid, Essay VII, "Reasoning II," in *Essays on the Intellectual Powers of Man*, ed. by Dugald Stewart (Charlestown, Samuel Etheridge, 1815), III, 265.

⁶ Prichard is perhaps best known for his formulation of the concept of moral insanity. As originally used by him this term had a much wider meaning than was given it later. There is no place in his classification of mental disorders for the depressions, unless they be included here—he described what seems to have been a manic outbreak as a typical case of moral insanity. See his work *On the Different Forms of Insanity in Relation to Jurisprudence* (London, H. Ballière, 1847), pp. 40-47.

natural impulses, without any remarkable disorder or defect of the intellect or knowing and reasoning faculties, and particularly without any insane illusion or hallucination

2 *Monomania*, or partial insanity, in which the understanding is partially disordered. . . .

3 *Mania*, or raving madness . . .

4. *Incoherence* or dementia . . .⁷

Prichard's "moral insanity" does not appear as a disorder of the "special moral faculty" of the Scottish school, and though he made no special appeal to psychology, a definite psychology underlies his concept of insanity when he says that incoherence or dementia is due to "confounding or destroying the connections or associations of ideas."⁸ His trend away from psychology was to be the dominating tendency in psychiatric writings from his own day even to the present.

Samuel Worcester's *Insanity and Its Treatment*,⁹ published in 1882, was compiled in the spirit of Benjamin Rush, the author made an honest attempt to gather all the available information on psychology and to make what use of it he could to throw light on the problems of mental disorder. Worcester, like Rush, was influenced by the Scottish philosophers, but indirectly, by way of the work of a French author, Prosper Despine, *Docteur en Médecine*.¹⁰ He was also influenced by J. L. C. Schroeder van der Kolk (1797-1862),¹¹ a Dutch author often quoted in the writings of the period.

In those days the work of Fritsch and Hitzig had stimulated a lively interest in localization of cerebral functions in terms of nerve cells and their connections. Worcester, like Van der Kolk, found it necessary to support a kind of Cartesian dualism and felt he had to adopt Griesinger's concept of the mental disorders. He wrote: "What I would especially impress upon your minds is that insanity is one of the neuroses, always

⁷ *A Treatise on Insanity and Other Disorders Affecting the Mind* (Philadelphia, Haswell, Barrington, and Haswell, 1837), pp. 16-17.

⁸ *Ibid.*, p. 17

⁹ New York and Philadelphia, Boericke and Tafel. Prior to Worcester, Andrew Jackson Davis wrote a book of a popular character entitled *Mental Disorders or Diseases of the Brain and Nerves* (Boston, W. White, 1871). Worthy of mention also is Isaac Ray (1807-1881), *Contributions to Mental Pathology* (Boston, Little Brown, 1873). Ray in this work gives no indication of his sources.

¹⁰ His work was entitled *Psychologie naturelle; étude sur les facultés intellectuelles et morales dans leur état normal et dans leurs manifestations anormales chez les aliénés et chez les criminels* (Paris, F. Savy, 1868). See a review of this work in *Edinburgh Med. J.*, XV (1870), Part 2, pp. 913-925.

¹¹ *The Pathology and Therapeutics of Mental Diseases*. Trans. from the German by James T. Rudall, F. R. C. S. (London, J. Churchill and Sons, 1870)

an actual disease of the brain."¹² But at the same time he supposed an independently operating mind which "is in the most intimate way connected with these cells and receives impressions through them, but which can act upon them."¹³ Van der Kolk insisted upon a spiritual telegrapher in the cerebral telegraph office.¹⁴

Worcester's work was closely followed by *A Treatise on Insanity in Its Medical Relations*, by William A. Hammond¹⁵ (1828–1900), a neurologist. Like most similar works of the period it started with a preliminary investigation of the nature of the mind and its functions. Whence was Hammond's psychology derived? From reading the text one is inclined to say mainly from his own rather crude speculations on information gathered from his study of anatomy and the autopsies he had witnessed. He also made experiments on himself to show that "increased use of the brain causes increased decay of its tissue, as demonstrated by the largely augmented quantity of phosphates excreted by the urine."¹⁶ Hammond was acquainted, however, with the *Senses and Intellect* of Alexander Bain. He also knew something of the work of Magendie, Todd, Carpenter, Luys, Broca, Fritsch and Hitzig, Nothnagel, Meynert, and Ferrier on the localization of functions in the brain. He had read Hartley and James Mill and disagreed with their identification of will and desire. And so, along with anatomy and psychology, he had dipped into psychology and philosophy. He was also acquainted with various French and German writers on insanity—which he himself defined as "A manifestation of disease of the brain, characterized by a general or partial derangement of one or more faculties of the mind, and in which, while consciousness is not abolished, mental freedom is weakened, perverted, or destroyed."¹⁷

To Hammond mental function was in general brain function, though he admitted that it might be at times a function of the spinal cord. The mind was a "force produced by nervous action."¹⁸ Of two individuals otherwise alike, one with the larger brain would have the greater mental efficiency.¹⁹

¹² *Insanity and Its Treatment*, p. 15 Worcester then cites Griesinger and others in support of this statement.

¹³ *Ibid.*, p. 18.

¹⁴ See review in *Edinburgh Med J*, XV (1870), p. 828

¹⁵ New York, Appleton, 1883.

¹⁶ *Ibid.*, p. 13, citing Urological Contributions Also, *Am J Med Sci* (1856), p. 330, and *Physiological Memoirs* (Philadelphia, 1863), p. 17

¹⁷ *A Treatise on Insanity*, p. 265

¹⁸ *Ibid.*, p. 9

¹⁹ *Ibid.*, p. 13; also pp. 101 ff.

Hammond's chapter on the treatment of insanity naturally has nothing to say about psychological techniques. It is largely concerned with a discussion of hospitalization, mechanical restraint, moral treatment (which he understood as rest cure), schooling, physical occupations, baths, and medical treatment.

In the seventeen years that elapsed between the appearance of Hammond's *Treatise on Insanity* and the close of the century, American psychology was to be profoundly influenced by the new experimental psychology of Wundt. The first edition of his *Grundzüge der physiologischen Psychologie* appeared in 1873,²⁰ the second in 1880,²¹ the third in 1887.²² Although by this time Wundt had begun to exercise his great sway over American psychology, he never had more than a trace of influence on American psychiatry. This, as Zilboorg points out,²³ was to develop principally along the lines of hospital reform and management. The second edition of Wundt's *Grundzüge* had been out for about two years when Worcester's work on insanity and Hammond's treatise appeared, but it seems to have been unknown to these writers or to professors of psychiatry in American universities. Thus E. C. Spitzka, whose primary orientation was neurological, in his *Insanity, Its Classification, Diagnosis, and Treatment*,²⁴ wrote that "Insanity is a term applied to certain results of brain disease and brain defect which invalidate mental integrity."²⁵ The sources of his psychology seem to have been Griesinger, Ribot, Van der Kolk (whom he terms the renowned), Neumann, D. Hack Tuke, Morel, Maudsley, Voisin, and Krafft-Ebing. Of these the only one well known as a psychologist was Ribot. American psychiatry had definitely turned its back on psychology and gone to neurology for information about the mind of man. The treatment of mental disorders was to remain largely general hospital care—sometimes good, but often bad—until, with the advent of Freudian psychoanalysis, it was to rightabout-face in its blind neurological alley and go to the opposite extreme of a purely analytical psychotherapy.

In the meantime American psychology was to go through a process of

²⁰ Leipzig, Engelmann

²¹ *Ibid.*, 2 vols

²² *Ibid.*

²³ *A History of Medical Psychology* (New York, W. W. Norton, 1941), p. 410.

²⁴ New York, Birmingham, 1883. Spitzka claims in his preface that his book is "the first systematic treatise on insanity published on this side of the Atlantic since the days of the immortal Rush" (p. 9).

²⁵ *Ibid.*, p. 17

development which in various ways has influenced psychiatric research but has had very little influence on the writers of standard textbooks of psychiatry. Not yet written is a textbook of psychiatry, in any language, based on a synthesis of the experimental research in psychology and psychiatry.²⁶ In no other branch of medicine have writers so neglected the research work in their own field. The fact that psychiatrists have not so used the data of experimental psychology—whereas physicians have utilized the contributions of physiology—has been pointed out by others. Thus Hunt and Landis summarize their study of “The Present Status of Abnormal Psychology”:²⁷ “Our analysis and tabulations show that the field of abnormal psychology has at present a body of experimental knowledge which has not been utilized to any extent by the authors of textbooks. Many of the text-books contain collections or systematizations of material which is frequently irrelevant and morbid rather than pertinent and scientific.”

Again, Cameron points out that standard textbooks of psychiatry contain only meager references to the work of psychologists, but he says, “The publications of workers in the research field to an increasing extent draw upon the findings of those working in psychology, in sociology, in anthropology as well as the reports of those engaged in the biological sciences.”²⁸ Cameron’s *Objective and Experimental Psychiatry* is an attempt to throw light on the problems of psychiatry through a survey of the scientific literature in these various fields. The literature was vast, and Cameron’s attempt merely touches, in a very spotty fashion, the available material.

The following table lists several psychologists whose names were looked for in ninety-three textbooks of psychiatry appearing in the United States from 1861 to 1942, and gives the number of times a reference to their work was found.²⁹

²⁶ The closest approach to this is the *Handbuch der Geisteskrankheiten*, ed Oswald Bumke (Berlin, Julius Springer, 1928 ff).

²⁷ W A Hunt and Carney Landis, “The Present Status of Abnormal Psychology,” *Psychol Rev*, XLII (1935), 89

²⁸ D Ewen Cameron, *Objective and Experimental Psychiatry*. (2d ed, New York, Macmillan, 1941), p v

²⁹ I am indebted for the preparation of this table to Miss Marie Wolf, statistical assistant in the Department of Psychology and Psychiatry at the Catholic University of America

Ach, N.	0	Lotze, R. H.	2
Allport, G. W.	1	McDougall, W.	11
Anderson, J. E.	1	Marston, L. R.	0
Bain, A.	2	May, M. A.	4
Baldwin, J. M.	3	Meinong, A.	0
Binet, A.	15	Meumann, E.	0
Brentano, F.	1	Moore, T. V.	1
Bühler, Charlotte	0	Muller, G. E.	1
Burnham, W. H.	2	Munsterberg, H.	2
Burt, C.	0	Murphy, Gardner	0
Calkins, M. W.	1	Ogden, R. M.	0
Cattell, J. McK.	2	Otis, A.	1
Claparede, E.	1	Paterson, D. G.	2
Downey, J. E.	0	Pearson, Karl	2
Dunlap, K.	11	Piaget, J.	2
Ebbinghaus, H.	4	Pintner, R.	1
Ehrenfels, C. v.	1	Pressey, L. C.	1
Fechner, G. T.	6	Ribot, T. A.	8
Froebes, J.	0	Rivers, W. H. R.	6
Galton, F.	8	Roback, A. A.	1
Gates, A. I.	1	Rorschach, H.	3
Gemelli, A.	0	Rosanoff, A. J.	5
Gesell, A.	3	Sanford, E. C.	1
Goddard, H. H.	9	Seashore, C. E.	1
Goodenough, F. L.	1	Spearman, C. E.	1
Gruender, H.	0	Stern, W.	2
Hall, G. S.	8	Strong, E. K.	2
Hartshorne, H.	0	Stumpf, C.	2
Heidbreder, E.	2	Terman, L. M.	6
Hollingworth, H.	1	Thorndike, E. L.	3
Hull, C. L.	1	Thurstone, E. L.	0
Jaensch, E. R.	0	Titchener, E. B.	4
James, W.	14	Travis, L.	1
Kelley, T. L.	1	Washburn, M. F.	0
Koehler, W.	4	Watson, J. B.	6
Koffka, K.	1	Wertheimer, M.	1
Kuhlmann, F.	0	Wheeler, R.	3
Külpe, O.	1	Woodrow, H.	1
Ladd, G. T.	4	Wundt, W.	10
Lange, C. G.	13	Yerkes, R. M.	3
Lashley, K. S.	1	Zwaardemaker, H.	1
Lindworsky, J.	0		

We turn to a survey of experimental psychology and its relation to psychiatry. Every development of any extent in psychology, whatever its value, has found some kind of repercussion in psychiatry.³⁰ It will therefore be of some importance to touch on the major trends in empirical psychology, from its origin with Weber, Fechner, and Wundt to the present, and see how they have been reflected in psychiatry.

Experimental psychology had its origin in the attempt of Ernst Heinrich Weber (1795–1878) to write for physiology its unwritten chapter on sensation. It sprang into being as psycho-physics when Gustav Theodor Fechner (1801–1887) published his *Elemente der Psychophysik* in 1860. But it was Wilhelm Wundt (1832–1920) who systematized experimental psychology and drew into its field students from all over the world. Anyone in the last quarter of the nineteenth and the first quarter of the twentieth century who thought of laying the foundations of psychiatry in a scientific psychology naturally turned to Wundt.

Emil Kraepelin (1856–1926) studied medicine with the express purpose of becoming a psychiatrist.³¹ It was natural then that he should attempt to lay the foundation in psychology and that he should associate himself with Wilhelm Wundt in Leipzig, then regarded as the center of the psychological world. As Kraepelin tells us in the preface to his early work, *Ueber die Beeinflussung einfacher psychischer Vorgänge durch einige Arzneimittel*, he commenced with Wundt at Easter, 1882, studies that were to take nearly ten years to complete. The concept back of the undertaking seems to have been an approach to the study of the major mental aberrations of insanity through an experimental investigation of the minor disturbances of mental function caused by various pharmacologicals. The work was continued by his students in Kraepelin's *Psychologische Arbeiten*.³² For some years he and his students were actively engaged in experimental studies which might throw some light on the theory of mental function and its aberrations. Kraepelin's attention was gradually absorbed by an attempt to fill out the individual pictures of the clinical entities of psychiatry. To accomplish this end he made

³⁰ Thus we have J. G. Spurzheim (1776–1832), *Observations on the Deranged Manifestations of the Mind or Insanity* (London, Baldwin, Cradock and Joy, 1817) The third American edition appeared in Boston in 1836 Spurzheim found a convert in Andrew Combe, M.D., whose *Observations on Mental Derangement* (Edinburgh, J. Anderson, Jr., 1881) was an application of the principles of phrenology to the elucidation of the causes, symptoms, nature, and treatment of insanity.

³¹ Mayer-Gross, *Deutsch med Wochenschr*, LII (1926), 1956

³² 9 vols, 1896–1928.

use not only of the mental history of the patients but also of all the light that could be thrown on the problem by experimental psychology, histology, neuropathology, and the various subsidiary branches of research centering in psychiatry. But the experimental psychological investigations were never synthesized into a valuable, organized whole.

(Georg) Theodor Ziehen presents an even closer union of psychology and psychiatry than did Emil Kraepelin. In fact, his whole lifework has been an attempt to found psychiatry upon psychology, and that too upon the experimental psychology of Wundt. In an address delivered in 1900, as he entered upon his duties as Ordinary Professor of Psychiatry at Utrecht, Ziehen outlined his ideal of developing in psychiatry the experimental methods that had originated in the work of Fechner and Wundt in psychology.

Scientific psychiatry is not possible without a scientific psychology . . . At the present time this can only be a matter of the so-called physiological or experimental psychology, that is that psychology which not only does its research in a purely empirical manner but also employs the physiological method, experiment in its widest extent, and never ignores the evident parallel relationships of mental processes to physiological processes of the brain. Psychiatry is just now commencing to learn and develop the vast findings of experimental psychology in the works of Fechner, Wundt and many others.³³

Ziehen then goes on to point out that the psychology which is to lie at the basis of all psychiatry is one that recognizes as its essential elements: sensations, mental images, association of ideas, and motor reactions or acts and tones of feeling.

"The experimental study of sensations, the cornerstones of our mental life, must precede every other type of examination (*Prüfung*)."³⁴ It was this assumption that doomed his program to failure. Nevertheless, some ten years later he was still enthusiastically carrying out the program he had outlined.³⁴

The fundamental difficulty with the Wundtian experimental psychology was that it confined its attention to experiences that could be presented by mechanical devices and in some manner registered by a recording apparatus. So we have such ingenious constructions as Sommer's tri-

³³ Theodor Ziehen, *Ueber die Beziehungen der Psychologie und Psychiatrie, Rede gehalten bei dem Antritt der ord. Professur für Psychiatrie an der Universität Utrecht am 10 Oktober 1900* (Jena, G. Fischer, 1900), pp. 2-3

³⁴ "Vorträge über die Grundzüge der modernen Psychologie und Psychiatrie," *Deutsch med Wochenschr.*, XXXVI (1910), 2108-2109

dimensional analyzer, the various tachistoscopes, the pneumograph, the plethysmograph, the psychogalvanometer, and so on. The assumptions of most experimental psychologists were those of Ziehen: All mental phenomena may be analyzed into certain elements—sensations, mental images, associations leading from one mental image to another, motor reactions and the resultants of sensory cognition, the simple affective processes or tones of feeling. Along with these, as Lowenstein pointed out, was the false assumption that “Disturbances of elementary mental functions can correspond only to changes in the somatic elements,”⁸⁵ and “one only needs to analyze clinical symptoms psychologically into disturbances of elementary mental functions to obtain at the same time a complete picture of their anatomical structure”⁸⁶

Various universities and mental hospitals in this country and abroad at times tolerated and occasionally encouraged the presence of an experimental psychologist in their laboratories;⁸⁷ but gradually the experimental psychologist gave way to the clinical psychologist, with his battery of tests to measure the cognitive level of the patient’s mental ability. As Löwenstein remarked: “Psychological apparatus has long ago found its way to the lumber-room of the psychiatric clinics where it remains covered with dust and rusting away without having left behind any gap in the armament of the research worker or the practitioner.”⁸⁸

Löwenstein here called attention to a condition which existed as a matter of fact in Germany at the time he wrote. Was it a tragedy to be mourned or a consummation devoutly to be wished? In the mind of the writer, it was rather a tragedy to be mourned. It was a living example of the necessity for sound theory in the direction of experimental research. Psychological research has been hampered by unwarranted neurological assumptions inherited from the days of Griesinger in Germany and Hammond in the United States.

Edward Bradford Titchener dominated experimental psychological thought in the United States in the early days of its development, and he handed on to his students the inadequate English philosophy in which he was educated. The result was that experimental psychology was un-

⁸⁵ Otto Löwenstein, “Die Bedeutung der experimentalpsychologischen Forschung für die klinische Psychiatrie,” *Arch. f. Psychiat.*, LXXVI (1926), 253.

⁸⁶ *Ibid.*, p. 254.

⁸⁷ For example, Shepherd Ivory Franz (1874–1933), at St. Elizabeth’s Hospital, Washington, D. C.

⁸⁸ Otto Lowenstein, *op. cit.*, p. 242.

able to rise above the sensationalism which it had inherited, and when the psychiatrist turned to it for real help in his psychological problems it had nothing to offer. Experimental psychology was dominated by a metaphysics rather than a free spirit of scientific research.

The following quotation from MacCurdy's criticism of Dunlap expresses the reason why psychiatrists found nothing when they turned to scientific psychology for help and had to set about creating a psychology of their own.

One effect of the growth in importance of natural science has been to give most people the conviction that somehow chemistry will solve the problems of biology and biology dispel the mysteries of psychology. This belief partakes of the nature of religion³⁹ or superstition in the proper sense of these terms. So strong is this belief that few scientists are without it. With many it is an overt article of faith, while with a few it is merely an unacknowledged motive. . . .

The school of psychology in which these workers were trained dealt with psychology as a branch of metaphysics, or as an experimental study of the physiology of the special senses and of the simpler intellectual functions, such as memory, attention, etc. This training leaves one unprepared to examine or understand that large mass of phenomena which have been studied by psychiatrists during the last twenty or thirty years. These phenomena have to do mainly with instinctive and emotional life. The psychiatrists have had no more training than the psychologists—in fact not as much, as is evidenced by their deplorable terminology—but they have at least gone honestly to work to collect the facts and speculate about them in mental terms. The academic psychologist, on the other hand, has been faced with a dilemma—he had either to admit ignorance and incapacity or to avoid the issue. Professor Dunlap is one of those who has chosen the latter way out. He has fabricated a scheme of psychology that leaves to the psychologist only the study of what he knows about consciousness. All else is physiology.⁴⁰

If anyone will examine the "scientific psychologists" of the last fifty years, he will find that few can escape the criticism that MacCurdy leveled at Dunlap. The "scientific psychologists" at times have raised an outcry against metaphysics and have prided themselves on being "scientists." But as a matter of fact they have been metaphysicians themselves; they merely deny all metaphysics except their own. They belong to the school referred to by MacCurdy, which seeks the explanation of mental phenomena in the last analysis in the principles of chemistry. The unwillingness of the vast majority of "scientific psychologists" to step out beyond

³⁹ The author would not accept the implied definition of religion.

⁴⁰ John T. MacCurdy, "Psychiatry and 'Scientific Psychology,'" *Mental Hygiene*, V (1921), 264.

the narrow confines of their hopelessly inadequate metaphysics has brought psychology to a condition in which it seems about to disintegrate and to have its scattered particles absorbed by philosophy, physiology, education, psychiatry, and social work.

But the picture given us of the demise of psychology in Germany was not the end of the chapter. What was true in Germany in 1926 is not true in the United States in 1944. Interest in the possibilities of experimental psychology for psychiatric research has revived. Thus Erickson writes

In regard to the promotion of actual investigative work, a number of mental hospitals have demonstrated the worth and feasibility of such a venture. One such institution with which the author is well acquainted, namely, the Worcester State Hospital, has been able to develop a number of significant research projects by virtue of its practice of inviting to the hospital advanced psychology students and research workers in special fields. There under the auspices of the hospital and in the capacity of "special," "guest," or "volunteer" workers, they engage in research of interest to themselves but pertinent to psychiatry, using the hospital and its facilities as a laboratory and receiving from their particular university scholastic credit if needed for their work.⁴¹

It has been pointed out by Whitehorn and Zilboorg that in the *American Journal of Psychiatry*, the *Archives of Neurology and Psychiatry*, and the *Journal of Nervous and Mental Disease* "psychological studies rose from a total of 817 pages published in the years 1921-1925 to a total of 1923 pages in the years 1926-1930, thus surpassing in volume the traditional clinical papers which had declined slightly (1622 to 1492)."⁴² Many of these contributions have been made by physicians rather than by psychologists. Serious-minded psychiatrists could not find what they wanted in the textbooks of psychology, and so they launched original investigations of their own; they sometimes neglected the literature available in psychological periodicals.

The movement of developing a scientific psychology to form the basis of psychiatry continues vigorously in various quarters. The founding of such a journal as *Psychosomatic Medicine* must be looked upon as an organized attempt to utilize the data of psychology and of all the sciences in any way affiliated to psychiatry to throw light upon the problems of the mind and its disorders. In their introductory statement the editors

⁴¹ Milton H. Erickson, "Opportunities for Psychological Research in Mental Hospitals," *Med Record*, CXLIII (1936), 390.

⁴² J. C. Whitehorn and Gregory Zilboorg, "Present Trends in American Psychiatric Research," *Am J Psychiatry*, XC (1933), 304-305.

thus defined the aims of *Psychosomatic Medicine*: "Its object is to study in their interrelation the psychological and physiological aspects of all normal and abnormal bodily functions and thus to integrate somatic therapy and psychotherapy."⁴⁸ As to the body-mind relation, the editors maintained that they had no interest in its metaphysics but nevertheless laid down the "thesis that there is no logical distinction between 'mind and body.'"⁴⁹

One might mention here the psychological movement in American psychiatry that had its origin in the genius of Adolf Meyer and was named by him "psychobiology."⁵⁰ Meyer tells us how he made a first attempt at teaching medical students a psychology of practical value in medicine, by giving a course in psychology, in collaboration with Prof. J. B. Watson and Prof. Knight Dunlap, at Johns Hopkins University in 1914. Meyer was evidently not pleased with the contributions of Watson and Dunlap; from 1915 on he alone conducted the course.⁵¹ Psychobiology therefore had its origin in the hopelessness of the behaviorism of John B. Watson and of the experimental psychology of Knight Dunlap.

Meyer felt the need for a psychology that would transcend the petty problems current in the laboratory investigations of the day. He laid down a principle which, while remaining empirical, would not cease to be practical: "What is of importance to us is the activity and behavior of the total organism or individual as opposed to the activity of single detachable organs."⁵²

Accordingly, each student was made to start the course in psychology with the history of his own personality. "Psychobiology," Meyer said, "as thus conceived forms clearly and simply the missing chapter of ordinary physiology and pathology, the chapter dealing with functions of the total person."⁵³

Meyer justly seeks to eliminate the contrast between physical and mental, which has existed since the days of Descartes, without perhaps realiz-

⁴⁸ *Psychosomatic Med*, I (1939), 3

⁴⁹ *Ibid*, p. 4.

⁵⁰ Adolf Meyer, "Objective Psychology or Psychobiology with Subordination of the Medically Useless Contrast of Mental and Physical" Paper read before the Section on Mental and Nervous Diseases at the Sixty-Sixth Annual Session of the American Medical Association, San Francisco, June 1915, published in the *J Am Med. Assn*, September 4, 1915, and republished in *Proceedings of the Fourth Conference on Psychiatric Education*, Baltimore, Maryland, April 8-10, 1926 (New York, National Committee for Mental Hygiene, 1938), pp. 307-313

⁵¹ *Ibid*, p. 308

⁵² *Ibid*, p. 310.

ing how close he comes to the concept of the substantial unity of the human individual which is a fundamental principle in the scholastic philosophy of Saint Thomas Aquinas.

One may look upon Wendell Muncie's *Psychobiology and Psychiatry*⁴⁸ and Frank Eugene Howard and Frederick Lorimer Patry's *Mental Health*⁴⁹ as products of the Adolf Meyer school of psychobiology.

While psychobiology and psychosomatic medicine are psychological movements, originating in medicine rather than in psychology, and are reactions to the inadequacy of the scientific psychology of the present era, one should not draw the conclusion that experimental psychology has accomplished nothing of value since the days of Ernst Heinrich Weber. The product of empirical research remains only an amorphous mass until it has been organized under true theoretical principles. The philosophy of psychology has been more at fault than the techniques of psychological research.

Individual workers have carried on their studies and have achieved results well worthy of attention by writers who are seriously attempting to organize the data of psychiatry. Some indication of the value and extent of this work is to be found in J. McV. Hunt's digest of "Psychological Experiments with Disordered Persons."⁵⁰

Oswald Külpe (1862-1915)⁵¹ was an experimental psychologist with a deep interest in philosophy. He lived in friendly contact with men eminent in the medical field—the physiologist von Frey, the psychiatrists Riegel and Weygandt, and the biologist Boveri. He received from the University of Giessen the doctorate in medicine *causa honoris*, and in thanks for this honor we have from him the little work *Psychologie und*

⁴⁸ St. Louis, C. V. Mosby, 1939.

⁴⁹ New York and London, Harper, 1935.

⁵⁰ *Psychol. Bull.*, XXXIII (1936), 1-58. This gives only the studies published in English and even in this field leaves various lacunae. The article digests some 210 references to the problem. It refers to the previous digests of F. L. Wells, "Experimental Pathology of the Higher Mental Processes," *ibid.*, X (1913), 213-224, F. L. Wells, "Experimental Psychopathology," *ibid.*, XI (1914), 202-212; and A. Hoch, "A Review of Some Psychological and Physiological Experiments Done in Connection with the Study of Mental Diseases," *ibid.*, I (1904), 241-257. See also, Madison Bentley, *General and Experimental Psychology in the Problems of Mental Disorder*, ed. Madison Bentley and E. V. Cowdry (New York, 1934), pp. 275-313.

⁵¹ For a short biographic notice see the Berlin letter in the *J. Am. Med. Assn.*, LXVI (1916), 668. For a fuller account see Erich-Leschke, "Oswald Külpe," *München med. Wochenschr.* LXIII (1916), 275-277. The Berlin letter gives the date of Külpe's death as December 31st, the Munich account as December 30, 1915.

*Medizin*⁵² in which he enters a plea for the separation of experimental psychology from philosophy and for its association with medicine.

To American students of psychology Kulpe is known chiefly as the founder of the Würzburg school and for his clear distinction between thought processes and any kind of mere sensory phenomena. He took his doctorate under Wundt and became his assistant in 1887. In 1894, when only thirty-two years of age, Kulpe was called to Würzburg as professor of psychology and philosophy; he founded the Würzburg Institute (1896), and was succeeded by Karl Marbe⁵³ when he himself was called to Bonn to succeed Benno Erdmann in 1909. In 1913 Kulpe went to Munich as the successor of Theodor Lipps.

Kulpe's specific contribution to psychology was his recognition of the thought processes. His lifework was an attempt to break the hold of the narrow sensationalism of the day which made psychology incapable of rising to the demands of psychiatry and the needs of those who must deal with the living problems of human life.

The Würzburg school of psychology, with its recognition of intellectual thought processes, was not without its influence on psychiatry. In a meeting of the *Ostdeutscher Verein für Psychiatrie* held on July 24th, 1920 at Breslau, O. Bumke expressed himself as follows:

The hopes that psychiatry had placed in experimental psychology have not been fulfilled. At the same time the dominance of Association-Psychology has commenced to waver. Not only the anatomical relations, which even today are pretty securely anchored in the minds of most of our scientific colleagues, but also its purely psychological content is of doubtful validity, and to a wide extent directly refuted. More than twenty years ago von Kries formulated an illuminating critique of this kind of psychology. In the meantime the work of Messer, Buhler, Ach, Kulpe, and others has shown that it is impossible to trace back all thought to the play of associations of contiguity and similarity and the dominance of end ideas. Along with that it has been shown likewise, as an essential finding of this modern psychology of the thought processes, that we must recognize, besides the imaginal part of our cognitive processes which run their course in the form of memory images and thoughts formulated in words, also a non-imaginal part carried neither by any kind of imagery nor by words.⁵⁴

⁵² Leipzig, Engelmann, 1912. The work is reprinted from the *Zeitschr. f. Pathopsychol.*, Vol. I.

⁵³ Concerning whom, see Maria Schorn, "Das psychologische Institut der Universität Würzburg unter Karl Marbe," *Arch. ges. Psychol.*, XCV (1936), 162-199.

⁵⁴ Cf. O. Bumke, "Denkpsychologie und Psychiatrie," *Allg. Zeitschr. f. Psychiat.*, LXXVI (1920-21), 805. Bumke returned to this problem in "Psychologie und Psychiatrie," *Klin. Wochenschr.* (1922), Heft 1, pp. 201-204.

Bumke then went on to point out how various problems which psychiatry could not solve on the basis of association psychology become luminously clear in the light of the concept of nonimaginal thought processes: the interior flight of ideas, the statements of many patients with obsessive ideas; delusions of observation and reference; ideas of self-depreciation in early stages of melancholia; Freud's views on the appearance from the unconscious of ideas unformulated in words.

The attempt to cling to a pure sensationalism and to explain the objective reference of hallucinatory experience led psychiatrists into a strange series of theories. Thus an early theory was that, when hallucinations are looked upon as real objects, there must be foci of irritation in the sense organs or peripheral nerves, for the mind cannot help but regard those stimuli as objectives which reach the brain through the ordinary channels of sensory perception. When such foci were not found at autopsy, it was then thought that they should be sought in the subcortical ganglia. And when foci in the subcortical ganglia could not be found, Wernicke assumed the existence of "perceptual cells" in the cortex, in the end centers of the sensory pathways, that gave a feeling of objective reality whether stimulated by external or internal neurological processes.⁶⁵

Kurt Goldstein appealed to logical criteria for the objective reference in the judgment that the patient passes on the reality of his hallucinatory experience. He recognized the inadequacy of the philosophy of the current associational psychology and ranged himself consciously or unconsciously with the Würzburg movement, when he wrote his most illuminating study *Zur Theorie der Halluzination*.⁶⁶

Kulpe, like Adolf Meyer, revived some of the fundamental concepts of scholastic philosophy, without ever having had in his mind any such end when he commenced his experimental investigations. The present writer's *Cognitive Psychology*, which investigates normal mental life not only by experimental data but also by psychopathology, belongs to this school of neoscholasticism in which full play is given to intellectual processes in cognitive experience.

One must also mention Charles Spearman as belonging in this group. Spearman entered the field of psychology with his two articles, "The Proof and Measurement of Association between Two Things,"⁶⁷ and

⁶⁵ Cf. T. V. Moore, *Cognitive Psychology* (Philadelphia, J. B. Lippincott, 1939), pp. 293 ff.

⁶⁶ *Archiv f. Psychiat.*, XLIV (1908), 604.

⁶⁷ *Am. J. Psychol.*, XV (1904), 72-101.

"General Intelligence, Objectively Determined and Measured."⁵⁸ The recognition of a general intelligence distinct from specific sensory functions by Spearman's correlational technique was an independent line of evidence which, however, pointed in the same direction as the intellectualism of the Würzburg school. Spearman's research culminated in his three important works: *The Abilities of Man*,⁵⁹ *The Nature of Intelligence*,⁶⁰ and *Psychology down the Ages*.⁶¹ In the account of the statistically determined "orectic factors," which constitutes the forty-second chapter of the last work, one will find much of theoretical interest to psychiatry.

In addition, there are a number of pieces of experimental research which the Spearman school has made on the basic problems of psychology in psychiatry.⁶²

Perhaps one should mention here the writer's work, *The Essential Psychoses and Their Fundamental Syndromes*.⁶³ This was an attempt to determine mathematically the collocation of symptoms in the mental disorders by Spearman's tetrad difference technique. There has been much discussion about the objective validity of Kraepelin's "dismemberment" of the essential psychoses. The objective validity of the Kraepelinian entities was confirmed by the Spearman tetrad analysis. Each factor found by this analysis corresponds to a fundamental type of cognitive experience or affective behavior. Further studies demonstrated a correlation between the prepsychotic type of personality and the specific character of the mental disorder. "A mental disorder is an abnormality of human behavior dependent to a very great extent on the original psychobiological constitution of the patient. Emotional trends have a psychosomatic basis, and a psychosis is more likely to develop in individuals in whom this psychosomatic basis of emotional experience exists from early years in a condition of abnormal lability."⁶⁴

⁵⁸ *Ibid.*, pp 201-293

⁵⁹ New York, Macmillan, 1927

⁶⁰ London, Macmillan, 1923.

⁶¹ 2 vols, London, Macmillan, 1927

⁶² For instance, see the symposium by W Stephenson *et al* on "Spearman Factors and Psychiatry," *Brit J. Med Psychol*, XIV (1934), 101-135, and M R. Harbinson, "An Investigation of Deterioration of 'General Intelligence' or 'G' in Psychotic Patients," *ibid*, XVI (1936), 146-148. See also J. D M Griffin, "A Psychological Approach to the Problems of Psychiatry," *Am J Orthopsychiatry*, VI (1936), 61-70.

⁶³ "Studies in Psychology and Psychiatry," III (1933), No 3 (Baltimore, Williams and Wilkins)

⁶⁴ T V Moore, "The Prepsychotic Personality and the Concept of Mental Disorder," *Character and Personality*, IX (1941), p 187

A character study' based on items of behavior suggested by the symptoms of psychotic patients gave evidence of the existence of a number of more or less primary and independent traits in human emotional life.⁶⁵

The Spearman technique leads to essentially the same analytic groups as Thurstone's Vector Analysis. In his presidential address before the American Psychological Association in 1933, Thurstone reported on the results of analyzing the table of correlations of symptoms derived from our study, and he found essentially the syndromes that we reported.⁶⁶

Psychiatric research can be greatly aided by the methods of factor analysis developed in psychology.

In contradistinction to the Wurzburg school, behaviorism was interested in action proper. Behaviorism as a movement in American psychology had its origin in an article written by John B. Watson in 1913.⁶⁷ The word "behaviorism" has several times been termed an American synonym for materialism, and as a form of materialism its history goes back to the beginnings of philosophic thought. Furthermore, most of the fundamental concepts of Watsonian behaviorism had been more or less clearly expressed in the relatively recent past.⁶⁸ Watson's work grew directly, however, out of Pavlov's studies on the conditioned reflex.

Watson, though antagonistic to Freud on various points, was profoundly influenced by Freudian concepts. It has been said that his article on the "Psychology of Wish Fulfillment,"⁶⁹ "which explains and illustrates the Freudian concept of wish fulfillment with obvious enthusiasm, now reads like the lay commentary of a Freudian exponent."⁷⁰

On the other hand, behaviorism has not been without its influences on psychoanalysis. Dalbiez writes:

Frink employs the language of Behaviorism⁷¹ to describe the formation of psychodynamic neuroses and in particular to point out more clearly the part played by events of the past. It is an extremely convenient method and in this exposition I shall follow an exactly similar course, translating the Freudian

⁶⁵ En Hsi Hsu, *The Construction of a Test for Measuring Character Traits*, "Studies in Psychology and Psychiatry," VI (1943), No. 1 (Washington, D. C., Catholic Univ. of America Press).

⁶⁶ L. L. Thurstone, "The Vectors of Mind," *Psychol. Rev.*, XLI (1934), 1-32.

⁶⁷ "Psychology as the Behaviorist Views It," *Psychol. Rev.*, XX (1913), 158-177.

⁶⁸ Willard Harrell and Ross Harrison, "The Rise and Fall of Behaviorism," *J. General Psychol.*, XVIII (1938), 367-421 (a digest of 426 references to the literature).

⁶⁹ *Scientific Monthly*, III (1916), 479-487.

⁷⁰ Harrell and Harrison, *op. cit.*, p. 383.

⁷¹ *Morbid Fears and Compulsions* (New York, Moffat, Yard, 1918).

conception into the language of Pavlov's conditioned reflex. I am of course only concerned with terminology, and I do not thereby imply my own acceptance of the behaviorists, or of Pavlov's denial of the value of psychological introspection.⁷²

Behaviorism attracted so much attention in its early days that various attempts were made to evaluate this new school of psychology for psychiatric purposes. William A. White hailed it as "a useful variant in the course of psychological progress."⁷³ He pointed out that the Wundtian school of experimental psychology "had come to be essentially a laboratory discipline largely occupied with questions of neurophysiology and the physiology of the sense organs. . . . The old academic psychology had become sterile when it came to having anything helpful to offer in the solution of man's vital problems of living."⁷⁴ White, however, parted "company with the extreme behaviorists, who would discredit the internal evidence entirely."⁷⁵ As a matter of fact, he advocated a psychology of his own in which thought had value because of the conduct to which it led.

Behaviorism went on to develop in its own way; it denied the existence both of the conscious and the unconscious and conceived of man as a reflex machine, devoid of an interior mental life. The behaviorists, in attempting to be truly "scientific," deserted the study of man's vital problems of living for a new form of laboratory research. However, their concept of man as a reflex machine had something to do with the attempts of psychiatrists to modify behavior by changing the environment. Thus Helen Witmer, speaking of the treatment of behavior disorders of children by modification of their environment, says: "The theoretical basis for this is found in such diverse sources as behavioristic psychology, certain schools of sociology and that interpretation of Freudian psychology that places the repressing forces chiefly in the external environment."⁷⁶

Perhaps the most outstanding American psychiatric work based on behavioristic principles was *An Introduction to Objective Psychopathology* by G. V. Hamilton.⁷⁷

⁷² Roland Dalbiez, *Psychoanalytical Method and Doctrine of Freud* (New York, Longmans Green, 1941), I, 194.

⁷³ William A. White, "The Behavioristic Attitude," *Mental Hygiene*, V (1921), 2.

⁷⁴ *Ibid.*

⁷⁵ *Ibid.*, p. 9.

⁷⁶ Helen Leland Witmer, *Psychiatric Clinics for Children* (New York, Commonwealth Fund, 1940), p. 364.

⁷⁷ St. Louis, C. V. Mosby, 1925.

The European attitude toward American behaviorism was that of general lack of interest or adverse criticism, but there were not wanting those who would introduce into psychiatry a kind of behavioristic reflexology. Thus Lentz advocated a study of the patient's reflexes, as Ziehen felt that the foundation of the psychiatric study of the patient should be the measurement of his sensory thresholds. According to Lentz: "From the objective-physiological point of view, psychiatry is the science of pathological or inadequate conditioned reflexes."⁷⁸

As a present-day movement behaviorism has almost ceased to exist. According to Howell and Harrison,

Behaviorism must be viewed now as essentially an historical development of the recent past. Watson has withdrawn from psychology, Lashley has become quiescent on controversial matters, and both Peterson and Weiss are dead. Tolman has been drawn under the mantle of *Gestalt* and purposive psychologies and the resulting eclecticism is behaviorism in name only. Hunter and Kuo have forsaken the Watsonian orthodoxy but their deviations have attracted few followers, while the younger converts to behaviorism have become strangely silent. Of recent years the volume of literature on behaviorism has dwindled into a barely perceptible stream, and psychologists have grown weary of the very words.⁷⁹

There are signs, however, that behaviorism may live on a while longer in physiology. Thus Masserman seems strangely afraid to grapple with the facts of emotional experience in his studies of the affective states; his *Behavior and Neurosis*⁸⁰ will serve to focus attention on certain minor therapeutic procedures, but will offer no help to the psychiatrist dealing with the major problems of truly human conflict.

If behaviorism was short-lived and, as far as psychiatry is concerned, ineffectual, the newer trends of Gestalt psychology appear to have affected broader psychiatric circles.

In 1890 there appeared in the *Vierteljahresschrift für wissenschaftliche Philosophie* an article by Christian von Ehrenfels entitled "Ueber Gestaltqualitäten."⁸¹ The article had its immediate origin in Ernst Mach's *Bei-*

⁷⁸ A. K. Lentz, "Die psychologische und physiologische Methode in der Psychiatrie," *Monatsschr f Psychiat. u Neurol*, LVII (1924), 81-88

⁷⁹ *J General Psychol*, XVIII (1938), 401-402

⁸⁰ Jules H. Masserman, *Behavior and Neurosis; an Experimental Psychoanalytic Approach to Psychobiologic Principles* (Chicago, Univ of Chicago Press, 1943).

⁸¹ XIV, 249-292.

trage zur Analyse der Empfindungen,⁸² which pointed out that we can sense immediately a melody depending on the relation of tone to tone, though the tone relationships themselves are never sensed. Furthermore, in spite of the current sensationalistic epistemology, objects are perceived as wholes and not as bundles of sensations. Ehrenfels went on to point out a number of similar sensory percepts that involve the evaluation of the relation of part to part in some kind of unit-whole, such as the "habit" of a plant perceived by the botanist without any conscious analysis of specific characters, or the feeling for a certain style of architecture by which one at once assigns a building to its place in the various architectural strata. Strange to say, Ehrenfels even put the meaning of words and the consciousness of contradiction in the category of *Gestaltqualitäten*.

Ehrenfels' article might well have been relegated to the lumber room of psychological curiosities, if preparation for it had not been made by an earlier school of thought, arising in the Aristotelianism of Franz Brentano. Brentano was a Catholic priest who had taught philosophy in Würzburg and had left the Church in the time of the *Kulturkampf* in Germany, taking with him Carl Stumpf, then a seminarian preparing for the priesthood.⁸³

On leaving Würzburg in 1874 Brentano took the chair of philosophy to Vienna. He carried with him an Aristotelian-Scholastic philosophy—something new in the midst of the sensationalistic tendencies of the psychology of the day. Among his pupils were Alexis Meinong (1853–1920) and Christian von Ehrenfels. Meinong took up the discussion started by Ehrenfels and applied the concept of *Gestaltqualitäten* to the whole field of logic and epistemology. He distinguished between sensory data, which he termed *inferiora*, and intellectual meanings, which he named *superiora*. And so the older school of Gestalt psychology, or the school of Graz, was a continuation and development of the Aristotelianism of Brentano.⁸⁴

The new school of Gestalt psychology was a break with Aristotelian scholastic intellectualism and a return to sensationalism, in spite of the fact that it developed a destructive criticism of crude atomistic sensation-

⁸² Jena, G. Fischer, 1886.

⁸³ Oskar Kraus, *Franz Brentano* (Munich, Bech, 1919) Anhang I, "Erinnerungen an Franz Brentano" by Carl Stumpf.

⁸⁴ Cf. hereon T. V. Moore, "Gestalt Psychology and Scholastic Philosophy," *The New Scholasticism*, VII (1933), 298–325, VIII (1934), 46–80.

alism. It started with Wertheimer's experimental studies of the perception of movement.⁸⁵ Wolfgang Köhler's efforts to find an analogy to the psychological concept of total configuration in inorganic nature resulted in the publication of his *Die physischen Gestalten in Ruhe und im stationären Zustand*.⁸⁶ The attempt has been made to evaluate for psychiatry the concepts of this work, and to translate psychopathology into neuropathology making use of Köhler's concepts of the brain as a physical system of the language of expression. Thus Köhler's law of dynamic direction states

that any physical system is either in a state of requiredness, or is in a required end state. In states of requiredness, tensions exist and the forces of the system reorganize that system in the direction of the end state which may or may not be reached according to the prevailing constraining conditions. If the end state is reached, the dynamic direction ceases to function until some outside force again disturbs the system, thus creating a new state of requiredness. Köhler has pointed out that the brain, being a physical system, is governed by the same law.⁸⁷

The attempt to reduce psychopathology to these elementary Gestalt conceptions has not as a matter of fact advanced our theoretical knowledge of psychopathology. Nor does there seem to be any hope that elementary Gestalt function will be any more helpful in psychiatry than Theodor Ziehen's attempt to understand mental disorders by a careful investigation of the patient's thresholds of sensibility. As Bernfeld points out,

The great advantage of the Gestalt-theory in the eyes of the psychologist with a trend towards the conceptions of natural science is that part of it which has to do with physics and mathematical analysis. But he must not deceive us, for Gestalt-theory up to the present can only answer for an approach to the preliminaries to the solution of the central problem of every physical psychology,

⁸⁵ "Experimentelle Studien über das Sehen von Bewegungen," *Ztschr. f. Psychol.*, LXI (1912), 151-265. For a good history of the movement, see B. Petermann, *Die Wertheimer-Koffka-Köhlersche Gestalttheorie und das Gestaltproblem* (Leipzig, J. A. Barth, 1929). English translation, *The Gestalt Theory and the Problem of Configuration* (London, K. Paul, Trench, Trubner, 1932).

⁸⁶ Erlangen, Philosophische Akademie, 1924.

⁸⁷ George W. Kisker and George W. Knox, "Gestalt Dynamics and Psychopathology," *J. Nerv. and Mental Dis.*, XCV (1942), 475. The authors refer to Köhler's *Dynamics in Psychology* (New York, Liveright, 1940). But see also his *Physische Gestalten*. Clark L. Hull's attempt to translate psychoanalytic terminology into words familiar to behaviorists is worthy of mention here: "Modern Behaviorism and Psychoanalysis," *N. Y. Acad. Sci. Transactions*, I (1939), Sec. II, 78-82.

namely the measurement of the critical physiological and "psychological" processes.⁸⁸

Gestalt psychology has narrow limits "beyond which psychoanalysis masters those problems which come near to the heart of man and are of living vital importance."⁸⁹

Much more important than Kohler's attempt to define the physical chemistry of perception were the various experiments of Gestalt psychologists that demonstrate perception as a sensory process involving an awareness of the sensory effect of part upon part in a total sensory impression.

Thus, in general, an animal trained to react to the darker of two grays will continue to react to the darker in a new setting, even though it now rejects the very gray that it had just been choosing, for the gray it formerly chose in the old setting is no longer the darker but the lighter member of the new pair. Animals therefore react not to atomistic sensory elements but to the total sensory configuration. This experiment was regarded as a crucial test of the current atomic sensationalism and a triumph of Gestalt psychology in dealing successfully with a problem that the old sensationalism could not touch.

"The question of how the two sensations can be compared no longer exists, because the two sensations themselves do not exist. What we find is an undivided articulated whole. Let us call these wholes 'structures,' and we can then assert that an unprejudiced description finds such structures in the cases underlying all psycho-physical experiments, but never any separate sensations."⁹⁰

Various experiments since the time of these observations have shown that animals may be trained to react either to the relative differences in a total configuration or to isolated sensory intensities or qualities. Thus wasps may be trained to pick the further of two containers, or one in a fixed position.⁹¹ And it has been found that when rats have learned to choose a weight of 75 in preference to one of 25 they will at first still choose the 75 in preference to a weight of 250. However, our problem is

⁸⁸ Siegfried Bernfeld, "Die Gestalttheorie," *Imago*, XX (1934), p. 76.

⁸⁹ *Ibid*, p. 75.

⁹⁰ Kurt Koffka, "Perception an Introduction to the *Gestalt-Theorie*," *Psychol. Bull.*, XIX (1922), 542.

⁹¹ L. Verlaine, "L'instinct et l'intelligence chez les hyménoptères," *J de psychol.* XXXI (1934), 396; Donald K. Adams, "Recherches sur la comparaison successive avec grandes différences chez les rats," *ibid*, XXXIV (1937), 532-553. There are several similar pieces of research in the literature.

not an evaluation and critique of Gestalt psychology but its relation to psychiatry.

Some have seen an analogy between the insistence of Gestalt psychology on the necessity of taking into consideration the total impression in sensory perception and the stress that is now laid on studying the total personality when an individual presents himself for psychiatric treatment. The movement in American psychiatry toward the study of the whole personality derives from the psychobiology of Adolf Meyer and made its appearance long before the birth of the Wertheimer-Koffka-Kohler Gestalt psychology. Some investigators in this field, however, in America and elsewhere, have been led to study not only the individual as a whole but the individual in relation to his environment. Thus Schulte⁹² tells us that pondering over the principles of Gestalt psychology led him to attempt an explanation of the delusional system of the paranoiac.

The individual can no more be understood as an atom of society than a sensation can be perceived as an isolated element in a process of perception. The individual stands in relation to other individuals as an integrated part of a social unit. The attitudes of others and our appreciation of how others stand in relation to ourselves has a profound influence on the inner organization of our own mental life. When an individual is unable to become a homogeneous part of his social unit, he may react by isolation of himself and delusional interpretations of the behavior of those with whom he comes in contact. And so, says Schulte, we can arrive at an understanding of paranoia by considering the individual and his background as a whole, but we would never succeed in such an attempt by an atomic analysis of mental content.

Schulte's suggestion is valuable, but it seems to transcend the sensory limits of the Wertheimer-Koffka-Kohler concepts. It will be remembered that this school admits no *Gegenstände höherer Ordnung*—as Meinong would term them—no concepts of relation or intellectual interpretations of any kind, but only the total sensory impression. It is hard to see how the individual would be able to interpret the complex system of interrelation between himself and his social group, if he could only utilize his total sensory impression.

Wolff⁹³ made a more extensive attempt to point out the importance

⁹² Heinrich Schulte, "Versuch einer Theorie der paranoischen Eigenbeziehung und Wahnbildung," *Psychol. Forschung*, XV (1924), 1-23

⁹³ Werner Wolff, "Die Psychologie in der Psychiatrie; Gestaltliche Faktoren in der Psychiatrie," *Zeitschr. f. d. ges. Neurol. und Psychiat.*, CXVIII (1929), 733-751

of taking into consideration the whole configuration in the study of psychiatric problems. Important as this suggestion is, it does not constitute a new contribution of Gestalt psychology itself to the study of psychiatry. One might say, however, that the insistence of configurational psychologists on the importance of the total sensory impression has made many writers more alive to the importance of the integrated whole which ordinarily embraces intellectual as well as sensory elements.

These concepts of Gestalt psychology have merely a certain analogy with the principles of Adolf Meyer, which accentuate the importance of studying the individual as a whole in any attempt at psychotherapy. The work of Adolf Meyer antedates the birth of Gestalt psychology.⁶⁴ But from various sources the concept has developed that organs and elements with their chemical properties cannot tell the whole story of the organism. To mention a few of these, we have Hans Driesch, *The Science and Philosophy of the Organism*,⁶⁵ J. C. Smuts, *Holism and Evolution*,⁶⁶ Hans Spemann, *Embryonic Development and Induction*,⁶⁷ and J. von Uexküll, *Theoretische Biologie*.⁶⁸ From these writers and many others a vastly interesting and important body of knowledge has developed, giving many illuminating insights not only into the nature of the living organism but also into the preëstablished harmony between the organism and its environment.

Out of this knowledge has developed the attempt to regard the individual as a part of the social structure in which he lives and which gives him "the opportunity of sensing and observing the inadequacy of his neurotic adaptation (in its early and recent phases) as part of an undeveloped or maladapted social configuration."⁶⁹ The names of Trigant Burrow and Hans Syz are associated with this therapeutic movement in the United States.

But the most intimate connection between psychology and psychiatry has developed out of the attempt to deal with the educational and behavior problems of children by psychological and psychiatric techniques.

⁶⁴ Cf., e.g., Adolf Meyer, "The Role of the Mental Factors in Psychiatry," Amer. Medico-Psychol. Assn., *Proceedings*, 1908, 128-137.

⁶⁵ London, A. C. Black, 1908.

⁶⁶ New York, Macmillan, 1926.

⁶⁷ New Haven, Yale Univ. Press, 1938.

⁶⁸ 3d ed., London, Paul, Trench, Trubner, 1926.

⁶⁹ 2nd ed., Berlin, J. Springer, 1928.

⁷⁰ Hans Syz, "The Concept of the Organism-as-a-Whole and Its Application to Clinical Situations," *Human Biol.*, VIII (1936), 499-500 (an excellent study of the literature).

The origin of this child guidance movement is associated with the name of Lightner Witmer. A Philadelphia schoolteacher once told me how she brought to Witmer, in the first part of his career as a Wundtian psychologist, a boy with whom no one had been able to make even a beginning in the teaching of reading. She told Witmer that he as a psychologist should be able to solve the problem. Witmer was said to have tried various tests before he thought of examining the boy's eyesight. It was found that the child was sorely in need of glasses, and when these were supplied he promptly learned to read.

The real beginnings in the clinical psychology of childhood go back to a number of psychological attempts to measure mental abilities by various forms of testing. Perhaps the earliest effort of this kind was that of Francis Galton, who attempted to measure intellectual differences by determining the individual's power to discriminate differences in an ascending series of weights.¹⁰⁰ The influence of Weber's concept is here apparent, but the theory back of the plan was the philosophy of Locke.¹⁰¹

The term "mental tests" was introduced by Cattell in 1890 in an article in which he described tests he was then using at the University of Pennsylvania.¹⁰² Some of these tests had been published as early as 1885, and in 1889 Oehrn published the mental tests devised by Kraepelin.¹⁰³

In 1895 the American Psychological Association appointed a committee to discuss the ways and means of cooperation among the various psychological laboratories of the country in collecting data of mental and physical measurements to serve as a basis for standardizing tests to be used in the study of the individual.¹⁰⁴ This committee consisted of Cattell, Baldwin, Jastrow, Sanford, and Witmer.¹⁰⁵

Witmer tells us that in 1896, in an address before the American Psychological Association, he outlined his plans for the practical study of genetic and child psychology and the opening of "a psychological clinic, supplemented by a training school in the nature of a hospital school, for

¹⁰⁰ Cf. Francis Galton, *Inquiries into Human Faculty and Its Development* (London, Macmillan, 1883).

¹⁰¹ For the history of the early testing movement, see Joseph Peterson, *Early Conceptions and Tests of Intelligence* (Yonkers, World Book Co., 1925).

¹⁰² J. McKeen Cattell, "Mental Tests and Measurements," *Mind*, XV (1890), 373-381.

¹⁰³ A. Oehrn, "Experimentelle Studien zur Individualpsychologie, 1889, Dissertation Dorpat," republished, *Psychol. Arb.*, I (1895), 92-151.

¹⁰⁴ J. McKeen Cattell and L. Farrand, "Physical and Mental Measurements of the Students of Columbia University," *Psychol. Rev.*, III (1896), 618-648.

¹⁰⁵ "Clinical Psychology," *Psychol. Clinic*, I (1907-8), 5.

the treatment of all classes of children suffering from retardation or physical defects interfering with school progress."¹⁰⁶ In the summer of 1897 this clinic was opened. In the meantime the testing of students at Columbia University in New York had started another movement which was, however, destined to die out because of an inadequate theory of mental life.

This early test movement in the United States was profoundly affected by Wundtian psychology, its tendency was to measure simple sensory and motor processes on the basis of the assumption that intelligence can really be reduced to simple sensations and the speed of motor response. Furthermore, while the tests were given to a highly selected group of college and university students, all of about the same level of intelligence, it was soon discovered that they were of little value in discriminating between the abilities of members of the selected group.

A critique issued by the Cornell School did a good deal to put an end for some decades to the mental measurement of college students by specially devised psychological tests. Influenced by Binet's criticism of the tendency to test only simple sensory and motor function, Sharp at the Cornell laboratory attempted to measure also such functions as memory, imagination, attention, and artistic, musical, and literary ability. The Cornell verdict was that such tests could throw little light on mental life. "It is doubtful," the author wrote, "if even the most rigorous and exhaustive analysis of test results would yield information of importance as regards the structure of the mind. At all events, there is not the slightest reason to desert current laboratory methods for the 'method of tests.'"¹⁰⁷ This study was typical of a number of Cornell investigations later undertaken not to build up something new but to pull down the work of others. A more sympathetic approach to the problem might have given to Witmer's movement the aid it was eventually to receive from the work of Binet in France.

Somewhat later Clark Wissler¹⁰⁸ found that there was little correlation between current tests and the average grades of students in college examinations. As Peterson points out, the speedy end of the movement in American colleges was largely a result of these two studies. But as we

¹⁰⁶ Cf. Cattell, "Retrospect: Psychology as a Profession," *J. Consult. Psychol.*, I (1937), 1-3.

¹⁰⁷ Stella Emily Sharp, "Individual Psychology: a Study in Psychological Method," *Am. J. Psychol.*, X (1898-99), 389.

¹⁰⁸ "The Correlation of Mental and Physical Tests," *Psychol. Rev.*, Mon. Sup. III (1901), No. 6.

know now, the failure of Stella Sharp and Clark Wissler was due in large measure to the fallacy of concluding that, if a test does not discriminate between the abilities of individuals in a highly selected group of college students, it has no discriminative value. The test might, for instance, be very valuable in picking out morons in a school population. The other fallacy was that if these tests did not prove of value all tests would be equally useless.

In the meantime Alfred Binet (1857-1911) had been making a series of studies on individual differences. Binet¹⁰⁹ was educated in the law, but turned at once to experimental psychology. His first psychological study, "De la fusion des sensations semblables," was published in the *Revue Philosophique* in 1880. There followed a series of studies with his friend Charles Féré (1852-1907) in the field of abnormal psychology. In 1889, in conjunction with Beaunis, Binet established the laboratory of psychology at the Sorbonne, and in 1894 became its director. With the exception of some interest in microorganisms and insects, his attention was devoted to child psychology and the more theoretical problems of the field in general. In 1900, along with F. Buisson and Madama Kergomard, Binet founded the *Société libre pour l'étude psychologique de l'enfant*.¹¹⁰ France was awakening to the problem of the mentally retarded child. The Société attempted to have a survey made of the schools of Paris. Its efforts were crowned with success when in 1904 the Minister of Public Education appointed a commission for this purpose and Binet was asked to be a member.

Binet's recent researches had prepared him for the work he was called upon to do. In conjunction with Simon, he constructed the first intelligence test for the determination of the mental level of the school child. The publication of this test in 1905,¹¹¹ supervening on work of the psychological clinic started in 1897 by Witmer in Philadelphia, developed a movement of vast proportion which Witmer had named at its baptism *clinical psychology*. It is not for us to follow this movement in its wanderings from 1896 to the present. But we may remark that with the development of various techniques and statistical procedures, particu-

¹⁰⁹ For a biography of Binet, see Ed. Claparède, "Alfred Binet," *Arch. de Psychol.*, XI (1911), 376-388.

¹¹⁰ *Ibid.*, p. 380.

¹¹¹ Alfred Binet and Th. Simon, "Application des méthodes nouvelles au diagnostic du niveau intellectuel chez les enfants normaux et anormaux d'hospice et d'école primaire," *L'Année Psychol.*, XI (1905), 245-366.

larly factorial analysis, it is making ever more and more important contributions not only to the handling of practical problems of child guidance but also to the theoretical understanding of the human mind.

The movement was at first definitely psychological and awakened no sign of interest on the part of American psychiatrists. But in 1908 William Healy was appointed psychiatrist to the Juvenile Court of Cook County, Illinois. He writes as follows of his attempts to prepare himself for the problems with which he would be confronted when he opened his behavior clinic in 1909. *

In 1908 I journeyed about the country in quest for advice about a program for this new-born idea. I visited medical clinics, juvenile courts and institutions for juveniles. I consulted physicians, educators, psychologists, and others who would seem to be concerned with directing the lives of young people. With the possible exception of Witmer's clinic in Philadelphia where defectives were being observed and the beginnings of Goddard's work with Johnston at Vineland, also with defectives, there was not even the semblance of anything that could be called a well-rounded study of a young human individual.¹¹²

William Healy started the first psychiatric clinic with a primary interest in the behavior problems of children. Naturally, since Healy was associated with the Juvenile Court, his main interest was to be centered in the juvenile delinquent. But from the first he made use of the new tests devised by Binet and Simon, and he invented some of the earliest nonverbal or performance tests. The growth of the psychiatric clinic, which constituted the main branch of development of the movement for understanding and treating the behavior problems of children, derived from Healy. Healy too has been credited with introducing the social worker as a regular member of the staff of a child guidance center.¹¹³

Seashore writes, "About 1910 we established the psychological clinic patterned after the Pennsylvania Clinic under Witmer. This became the second psychological clinic in an American University."¹¹⁴

In 1914 there were nineteen psychological clinics in universities, normal schools, and medical schools in the United States. By 1934 only seven

¹¹² William Healy, *Twenty Five Years of Child Guidance Studies from the Institute for Juvenile Research* (Illinois Department of Public Welfare, 1934), pp. 1-2. Quoted from Helen Leland Witmer, *Psychiatric Clinics for Children* (New York, The Commonwealth Fund, 1940), p. 46.

¹¹³ C. M. Louttit, "The Nature of Clinical Psychology," *Psychol. Bull.*, XXXVI (1939), 366, quoting Stevenson and Smith, *Child Guidance Clinics; a Quarter Century of Development* (New York, Commonwealth Fund, 1934).

¹¹⁴ Carl E. Seashore, *Pioneering in Psychology* (Iowa City, Univ. of Iowa Press, 1942), p. 124.

of these were still in existence, although in 1935 there were eighty-seven clinics directed by a psychologist in the whole United States. In the same year there were also 755 behavior clinics for children, as listed in M. A. Clark's "Directory of Psychiatric Clinics in the United States."¹¹⁵

The psychological movement in "clinical psychology" has become predominantly a psychiatric movement. Although uninterested in child guidance at first, psychiatrists soon became suspicious of psychologists and the purely psychological clinic. At a meeting of the New York Psychiatric Society on December 6, 1916, a committee was appointed to inquire into the activities of psychologists. This committee's report was accepted, its recommendations were adopted and a copy was forwarded to the leading medical and psychological journals for publication. The resolutions were as follows:

1. We recommend that the New York Psychiatric Society affirm the general principle that the sick, whether in mind or body, should be cared for only by those with medical training who are authorized by the state to assume the responsibility for diagnosis and treatment.
2. We recommend that the Society express its disapproval and urge upon thoughtful psychologists and the medical profession in general an expression of disapproval of the application of psychology to responsible clinical work except when made by or under the direct supervision of physicians qualified to deal with abnormal mental conditions.
3. We recommend that the Society disapprove of psychologists (or of those who claim to be psychologists as a result of their ability to apply any set of psychological tests) undertaking to pass judgment upon the mental condition of sick, defective or otherwise abnormal persons when such findings involve questions of diagnosis, or affect the future care and career of such persons.¹¹⁶

These resolutions drew a sharp criticism from Shepherd Ivory Franz. He raised the question of whether or not "some of the abnormalities of which psychiatrists talk as fields for the psychiatric expert, such as criminality, prostitution, vagabondage, etc.," rightly belong to their field. He also asked: "How many psychiatrists are really able to deal with questions 'involving the whole mental and physical life of the individual?'" He wondered why a knowledge of physiology is looked upon as necessary for

¹¹⁵ *Mental Hygiene*, XX (1936), 66-129. For the other data see C. M. Louttit, "The Nature of Clinical Psychology," pp 371 ff.

¹¹⁶ Quoted from *Psychol Bull*, XIV (1917), 225. See also B. Cornell, "Psychology versus Psychiatry in Diagnosing Feeble-mindedness," *N Y State J Med*, XVII (1917), 485-486.

the physician but psychology is not regarded as a required subject for the psychiatrist. Furthermore, he said: "The psychiatrist would have the psychologist barred from dealing with abnormal persons, and the psychologist insists that the psychiatrist is not competent to give and to interpret mental tests."¹¹⁷

In a paper entitled "Psychiatry and Psychology," read at the meeting of the New York Psychiatric Society on January 3, 1917, Charles L. Dana called the attention of psychiatrists to the various types of psychological and psychoanalytic activities outside the field of the medical profession. Dana maintained that the medical profession should help and encourage these movements, but should adopt an attitude of watchful waiting, meanwhile guiding developments and making ready to propose limitations in due season.¹¹⁸

On April 30, 1920, a three-day conference on the relations between psychology and psychiatry was held under the auspices of the National Research Council.¹¹⁹ Seashore describes the atmosphere of the meetings: "There was in the situation every element of an intensive war. Both sides were contesting for 'living space.' Each considered the other an intruder."¹²⁰ Phyllis Blanchard attempted to clear the atmosphere by answering the stock objections against mental testing.¹²¹ She offered a clear explanation of the conditions under which reliable tests may be made and gave several case histories showing the value of tests to the psychiatrists. Her paper was rather unsympathetically criticized by Dr. Tilney.

At the White House Conference on Child Health and Protection, a special subcommittee was appointed to consider the relations between psychology and psychiatry. The report of the subcommittee, written by Dr. Bronson Crothers, touches upon the heart of the difficulty: "Education and psychology are sciences or 'disciplines' with definite tradition and techniques. 'Social science' has a definite meaning to some individuals. When doctors enter these fields they have no right to attempt to lead or dictate because their prestige as physicians gives them an advan-

¹¹⁷ Cf. Shepherd Ivory Franz, "Psychology and Psychiatry," *Psychol Bull.*, XIV (1917), 226-229.

¹¹⁸ Charles L. Dana, "Psychiatry and Psychology," *Med. Record New York*, XCI (1917), 265.

¹¹⁹ For an account of the membership and proceedings of this council, see Seashore, *op. cit.*, pp. 126 ff.

¹²⁰ *Ibid.*, *op. cit.*, p. 128.

¹²¹ Phyllis Blanchard, "The Value of Psychometric Examinations in Psychiatric Work," *Neurol Bull.*, III (1921), 370-378.

tage. The attempt to carry prestige beyond the field where it was earned, is the cause of most of the confusion which exists."¹²²

Very few psychiatrists have ever given psychometric tests. The ability of many psychiatrists to interpret a battery of psychological and educational tests does not compare with that of a good psychologist or a well-trained principal of a school. The result is that in spite of the anathemas of the New York Psychiatric Society in December, 1916, the diagnosis, treatment, and placement of children presenting educational difficulties in most school systems is determined by the school psychologist without reference to a psychiatrist.

After all, would a fair-minded study of the educational problems presented by large numbers of children all through the country lead to the conclusion that psychiatrists must take over the diagnosis and treatment of these educational problems? Properly trained psychologists are essential in any school system, and it will not be necessary or advisable to refer all the educational problems of a school system to a psychiatrist. While this is true, every school system will find a number of cases that cannot be handled by the psychological staff. A school psychiatrist or a child guidance center to which these problems can be referred is a practical necessity. The psychiatrist in charge of such a center should be able to understand and interpret psychological tests. Various signs indicate that as a matter of fact the relations between psychology and psychiatry are being worked out in the educational field on the basis of school psychologists and a child guidance center, with one or more full-time psychiatrists on the staff together with psychologists and social workers.

However, as a glance at the accompanying table will disclose, the tendency has arisen to eliminate the psychologist from the child guidance staff and to get rid of all psychometrics. Even when the child's presenting symptom is disability in school, the clinic makes no educational or psychological tests. Under the plea of treating ultimate causes, psychometry is neglected and the child's difficulty in school is attributed to faulty parental attitudes; the whole energy of the guidance center is devoted to uncovering and treating the home difficulties. The attitude of these child psychiatrists toward psychometric tests reminds one of that of the English physicians toward the stethoscope when it was first introduced.¹²³

¹²² White House Conference on Child Health and Protection, Sect. I., Med. Service, Committee C on Medical Care for Children, Subcommittee on Psychology and Psychiatry. *Psychology and Psychiatry in Pediatrics the Problem* (New York, Century, 1932), p. 24 (quoted from C. M. Louttit)

¹²³ Cf. Gregory Zilboorg, *A History of Medical Psychology*, pp. 351-352.

CLINIC STAFFS ACCORDING TO STATES*

State	Psychiatrist only	Psychiatrist and Psychologist	Psychiatrist and Social Worker	Full Staff
California	3	3	6	9
Colorado			1	3
Connecticut		2	2	12
Delaware		1		7
District of Columbia	1			4
Georgia				1
Illinois	3	4	13	15
Indiana		1		18
Iowa	1			2
Kansas		5		
Kentucky			1	1
Louisiana	1		1	3
Maine	1	1		
Maryland	23	1	1	2
(directors listed; appointments made through county health officers) *				
Massachusetts	1	1	4	43
Michigan	2	3	8	21
Minnesota		2	1	3
Missouri			1	5
Nebraska	1			1
New Hampshire	1	2	4	1
New Jersey	2	15	2	32
New York	24	12	135	53
North Carolina		2		2
Ohio	5	4	5	12
Oklahoma			2	
Oregon	2			1
Pennsylvania	3	36	6	31
Rhode Island				6
South Carolina			7	1
Tennessee			1	
Territory of Hawaii				1
Texas			2	3
Virginia		3		2
Washington			1	1
Wisconsin	1	2		1

* Milton E. Kirkpatrick, "Directory of the Psychiatric Clinics in the United States," *Mental Hygiene*, XXIV (1940), 252-292.

The movement toward the rejection of psychology and psychometrics in the child guidance centers in New York is evident. In no other state in the Union do we find such a high percentage of child guidance centers in which there is no psychologist on the clinical staff. The psychologist is eliminated from the staff not because of any lack of funds but because his services are regarded as superfluous.

As Helen Witmer says: "The present trend in child guidance clinics appears to be away from all routine examinations with the result that many patients are not given a psychological test. On the other hand some clinics are beginning to use their psychologists for therapeutic work, particularly with young children."¹²⁴ These clinics are developing a kind of social service psychiatry that seeks the origin of all the problems of child behavior somewhere along the axis whose extremes are rejection of the child by the parents at one end and overprotection at the other. Maladjustment in school fades out of the picture, for all maladjustment in social service psychiatry is home-maladjustment. The mental level of the child, or the use he has made of his educational opportunities, throws no light on his problem; the clinic therefore needs only a psychiatrist to analyze the child and a social worker to analyze the mother—the psychologist becomes superfluous.

Our criticism of this unfortunate trend must not be understood as in any way deprecatory or as undervaluing the need for investigation of parent-child relationships, but merely as an attempt to point out that when this relationship is studied so exclusively as to eliminate psychological and educational studies of the child, one is at times likely to miss the very essence of the child's problem. One can no more do without psychological and educational measurements in a child guidance center than a good hospital can dispense with its clinical pathologist and his laboratory.

The child guidance clinic has done much to throw light on parent-child relationships¹²⁵ and their importance in understanding the behavior problems of children. Is the effort to oust the psychologist likely to terminate the relations of psychology and psychiatry in the treatment of the problem child? Probably not. Just as the English physicians found

¹²⁴ Helen Leland Witmer, *op cit*, p. 369.

¹²⁵ See, for instance, Frederick H. Allen's stimulating *Psychotherapy with Children* (New York, W. W. Norton, 1942).

the stethoscope a jolly good instrument after all, child psychiatrists will in due season appreciate the contributions of psychology.

When we look back over the relations of psychology and psychiatry in the past hundred years, what a marvelous growth has taken place in each science! Benjamin Rush, just before the dawn of the hundred years we have reviewed, turned to psychology as he found it, but there was little to find. In the years that have elapsed psychology has grown. There is a large body of experimental empirical research in the field of psychology that has never been evaluated for psychiatry; there are methods and techniques that have been developed in psychology that would open up vast tracts of the *terra incognita* of psychiatry. Only when psychiatry is based on a sound and broadly adequate psychology can it make the progress that physiology has made possible for medicine.

HENRY ALDEN BUNKER

AMERICAN PSYCHIATRY AS A SPECIALTY

But one's difficulties do appear increased as soon as one embarks upon a medicopsychological career, because it becomes necessary to acquire such a variety and such a great amount of additional knowledge —Pinel

THE CARE of the human mind is the most noble branch of medicine " So wrote the Dutch jurist and humanist Hugo Grotius in the first half of the seventeenth century. But this far-sighted utterance—which has served as the motto of the *American Journal of Insanity* (since 1921 the *American Journal of Psychiatry*) for all but twelve of its one hundred years of existence—was scarcely descriptive of the opinions of the age in which Grotius lived. For in that age the care of the human mind could hardly be said to have been a branch of medicine at all.

It was Johan Weyer (1515–1588) who, antedating Grotius by only some sixty-five years, took the first steps since Hippocrates toward bringing mental disease within the province of medicine. It was Weyer who pursued "with relentless conviction" the aim of engrossing mental disorder into the sphere of medicine. It was Weyer who was the first physician to turn his major interest toward mental diseases, and in so doing to foreshadow (by more than two centuries) the establishing of psychiatry as a medical specialty.¹ Perhaps it is not altogether a coincidence that Weyer, who died in the year of the defeat of the Spanish Armada, lived in the most creative age that the Christian world has seen.

After Weyer, it must be said, a Dark Age again settled down over the attitude of the medical man toward mental disorder, for throughout the seventeenth century many great physicians continued to group the psychoses and the neuroses under the heading of demoniacal possession. This darkness was penetrated a century and a half after Weyer by Georg Ernst Stahl (1660–1734), whose conception of mental phenomena, well in advance of his time, played a part in enabling medicine to wrest mental disease from the clutches of superstition and cruelty.²

We have to pass over another one hundred years, very nearly, to reach Philippe Pinel (1745–1826), whose pioneer work of hospital reform and

¹ See Gregory Zilboorg, *A History of Medical Psychology* (New York, W. W. Norton, 1941), pp. 228, 230, see also Chapter III of the same author's *The Medical Man and the Witch during the Renaissance* (Baltimore, Johns Hopkins Press, 1935)

² Zilboorg, *A History of Medical Psychology*, p. 280

reorganization forged an indispensable link in the chain annexing psychiatry to medicine. He established a new tradition and opened a new perspective not only in the care but also in the study of mental patients. "It is now for medicine," he remarked after accomplishing this reorganization, "to complete the work and to collect not only most accurate information on the various types of mental disease, but also to explore the whole scope and limits of the reciprocal effect of moral and physical treatment."³ Thus did Pinel, nearly one hundred and fifty years ago, lay down the program of psychiatry as a medical specialty. For he took one of the most important steps—and one of the earliest after Weyer—in that long evolution, not even yet complete, whereby the victims of "insanity" became recognized as sick people "whose miserable state deserves all the consideration that is due to suffering humanity." Not dissimilar in its medical orientation to mental disorder was the pronouncement of Pinel's German contemporary, Peter Frank (1745–1821), who held that mental disease was as much to be studied by the doctor as pharmacology. The treatment of the mental patient as a medical patient, of mental disorder as a medical problem, had already been envisaged, it may be mentioned, by Joseph Daquin (1733–1815), the slightly older contemporary of Pinel. For Daquin had understood that "only in hospitals could one observe the various guises in which the malady appears, describe its history, regulate the therapeutic methods which cannot always be the same in all varieties of mental derangements, rid oneself of all the prejudices one has about the various types of insanity, and apply moral treatment in all cases."⁴ The hospitalization of the mentally ill—such as was projected by Daquin and carried into effect by Pinel—marks the beginnings of psychiatry as a specialty. It was this step that first made possible the observation and study of mental disorder.

Philippe Pinel and Peter Frank were both born in 1745. It is worth noting that Benjamin Rush, founding father of American psychiatry, was born in the same year. But even before Rush, and equally before Pinel, the insane were hospitalized in the United States. The reform instituted by Pinel is known to all; what is less well known is that the hospitalization of the insane was initiated in the United States, however incompletely and inadequately, more than forty years before Pinel ac-

³ *Ibid.*, pp. 326, 327.

⁴ René Semelaigne, *Les pionniers de la psychiatrie française* (Paris, Baillière, 1930), I, 77–79 (cited by Zilboorg, *op. cit.*, p. 317).

complished his revolutionary work; "all the known resources of benevolence and medical skill for the recovery of the unfortunate victims of insanity"—to borrow the somewhat rhetorical words of John P. Gray—"were applied long before Pinel unchained the madmen in the Bicêtre."⁵ For in 1751, in part through the interest and attention of Benjamin Franklin, an act was passed in Pennsylvania founding "a hospital for the reception and relief of lunatics, and other distempered and sick poor."⁶

If the hospitalization of the mentally ill marks the beginnings of psychiatry as a specialty, as making possible for the first time the observation and study of the "insane," its progressive development into a specialty in its own right is inseparable from the development of psychiatric teaching. It was Benjamin Rush (1745-1813) who probably gave the first lectures in this country on mental disorder. Appointed in 1791 to the chair of the Institutes of Medicine and Clinical Practice in the University of Pennsylvania, he delivered lectures on insanity to medical students, with clinical instruction as a part of his course.⁷ These lectures were published in 1812 under the title *Medical Inquiries and Observations upon the Diseases of the Mind*—the first textbook of psychiatry on this continent, "the first of the kind in the English tongue displaying thorough observation and original thought," as Isaac Ray called it.⁸ It was a work which went through four editions, the fourth in 1835, and long remained the standard work on its subject.⁹

⁵ John P. Gray, "Insanity, and Its Relations to Medicine," *Am. J. Insanity*, XXV (1868-69), 150.

⁶ *Ibid.*, p. 149. This, by the way, was not Benjamin Franklin's only contact with psychiatry. In 1784 he sat on a committee appointed by order of Louis XVI to investigate the practices of mesmerism. Nine years later, two of his fellow committee members, Bailly and the great Lavoisier, met their death by the guillotine, named for still another member of the same joint committee, Dr. J. I. Guillotin, friend of its inventor.

Among the pioneers in the hospitalization of the insane must also be included, of course, the Englishman William Tuke, who projected the York Retreat in 1792, the year before that in which Pinel was placed in charge at the Bicêtre. Somewhat as in the case of Benjamin Rush in 1783 in Philadelphia (see below), Tuke's proposal represented a protest against the conditions existing in the York Asylum—like Pinel's at the Bicêtre. Thus within ten years of one another, the American Benjamin Rush (1783), the Englishman William Tuke (1792), and the Frenchman Philippe Pinel (1793) "unchained the madmen."

⁷ John P. Gray, *op cit*, p. 163.

⁸ Edward Cowles, "Progress in the Care and Treatment of the Insane during the Half-Century," *Am. J. Insanity*, LI (1894-95), 14.

⁹ Of Benjamin Rush, "patriot, physician, and psychiatrist," it is worth noting—besides the fact that at the age of twenty-four he was the first formal professor of chemistry in America, the youngest member of the faculty of the first medical school in America (established in

It was only seven years after Benjamin Rush had begun his lectures on insanity to medical students (1798) that, "so far as we know," the first course of lectures given in this country to attendants was delivered by Dr. Valentine Seaman, in the New York Hospital.¹⁰

For many years the course of lectures given by Benjamin Rush remained unique in the annals of psychiatric teaching in this country.¹¹ In 1858, more than half a century after Rush began his lectures to medical students, it was predicted that the day was probably not far distant when "the study of insanity" would have its proper place in the medical school curriculum.¹² But as late as 1862, this prediction was still almost completely unfulfilled; in the pages of the *American Journal of Insanity* of

Philadelphia in 1765)—that on joining the staff of the Pennsylvania Hospital in 1783 he protested against the unsuitable basement quarters where the "lunatics" were lodged, and eventually succeeded in having a separate wing provided for them, that he was the earliest promoter of occupational therapy ("Certain employments should be devised for such of the deranged people as are capable of working . . ."), and that he believed that psychic disturbances were expressions not only of disease of the brain but of the whole organism Nathan G. Goodman, *Benjamin Rush. Physician and Citizen* (Philadelphia, Univ. of Pennsylvania Press, 1934)

¹⁰ M. W. Raynor, "New York Hospital School of Nursing Commemorative Exercises," 1927, p. 84; cited by Samuel W. Hamilton, in his chapter on the "History of American Mental Hospitals" in this volume

¹¹ This was less true of Rush's textbook, however, in the field of treatises on the general subject of mental disorder. Despite the complaint uttered at the ninth annual meeting of the Association of Medical Superintendents, in 1854, of the lack of a general treatise on insanity, the speaker averring indeed that he "knew of none such as were required by the American practitioner" (*Am. J. Insanity*, XI [1854-55], 56), there had already been published, in 1838, Isaac Ray's *A Treatise on the Medical Jurisprudence of Insanity*—a work of sufficient value to reach a third edition in 1853 and a fifth in 1871; in the latter year, indeed, it was referred to as the most original and comprehensive work on the medical jurisprudence of insanity in English, as it was also the first, except for a pamphlet by Haslam published in 1807 (*J. of Psychological Med.*, VI (1872), 106). There had also been published, in 1840, Thomas C. Upham's *Outlines of Imperfect and Disordered Mental Action*, a work containing the remarkable statement: "We have no hesitancy in admitting the doctrine that there may be other [than physical] causes of mental irregularity, more remote from common observation, and more intimately connected with the mind's interior nature and secret impulses" (see Professor Shryock's chapter in this volume). And finally, there had been published, in 1846, *The Treatment of Insanity*, by John M. Galt, the record of whose family, in connection with the first Virginia hospital for the insane, invites comparison, as Shryock has remarked (*op. cit.*), with the Tuke dynasty in Yorkshire. That there was, in fact, no dearth of American works on the general subject of mental disorder during the half century subsequent to the time of Rush is indicated by the publication of two volumes in addition to the three already mentioned. Francis Wharton's *A Monograph on Mental Unsoundness* (1855) and Isaac Ray's *Mental Hygiene* (1863). If no further works on the subject appeared in America until the 1880s, this might well be attributed, at least in part, to the fact that John Charles Bucknill and Daniel Hack Tuke's *Manual of Psychological Medicine*, first published in 1858, made such works superfluous.

¹² *Am. J. Insanity*, XV (1858-59), 227.

that year the complaint was voiced that "the great questions of the origin and working of our faculties and passions" were "entirely neglected in the medical schools both of Europe and America."¹³ Six years later Pliny Earle made the similar statement that "at present psychology is not taught in any one of the medical schools of the United States as a regular branch of study."¹⁴ It hardly invalidates these statements that, according to an editorial note in the *Journal*, Dr. Macdonald, "about the year 1840," delivered a course of lectures on insanity in the College of Physicians and Surgeons of New York City, that in 1847 Dr. Samuel Smith was appointed Professor of Medical Jurisprudence and Insanity at Willoughby University in Columbus, Ohio, and that in 1853 Dr. Pliny Earle delivered a course of lectures on insanity, also at the College of Physicians and Surgeons.¹⁵ These three very partial examples excepted, and disregarding the lectures given at the University of Pennsylvania by Benjamin Rush half a century earlier, the 1863 volume of the *Journal* stated editorially that to the medical faculty of Harvard University belonged the credit of being the first in this country to make mental disease a part of the course of study. "With them, however," the *Journal* comments, "it was but a partial measure, inasmuch as attendance upon the lectures delivered by Dr. Tyler of Somerville was optional with the student, and not essential to the conferment of his degree."¹⁶ In this same year, 1863, Pliny Earle was appointed Professor of Psychological Medicine in the Berkshire Medical Institute.¹⁷ In 1867 the Bellevue Hospital Medical College of New York City established a chair of Diseases of the Mind and Nervous System, to which William A. Hammond was appointed. Also in 1867 the College of Physicians and Surgeons of New York appointed T. Tilden Brown of Bloomingdale Asylum lecturer on Psychological Medicine and Medical Jurisprudence.¹⁸ In 1871 James P. DeWolf was appointed to the chair of Medical Jurisprudence by the Faculty of Medicine of Dalhousie College, Halifax, N. S.¹⁹ In 1872 J. K. Bauduy was appointed to the chair of Psychological Medicine in the Missouri Medical College, and John H. Callender, Superintendent of the Tennessee Asylum, as Lecturer

¹³ J. Parigot, "On Recent Psychological Literature," *ibid.*, XIX (1862-63), 10, 163.

¹⁴ Pliny Earle, "Psychological Medicine, Its Importance as Part of the Medical Curriculum," *ibid.*, XXIV (1867-68), 257.

¹⁵ *Ibid.*, XX (1863-64), 528, IV (1847-48), 181.

¹⁶ *Ibid.*, XX (1863-64), 359.

¹⁷ Pliny Earle, *op cit*, *Am J Insanity*, XXIV (1867-68), 257, footnote.

¹⁸ John P. Gray, *op. cit.*, p. 166.

¹⁹ *Am J. Insanity*, XXVII (1870-71), 504.

upon Insanity, its Causes and Treatment, in the Medical Department of the University of Nashville.²⁰*

Pliny Earle in 1868 took for granted, not without justification, the existence of psychiatry as a specialty—a specialty, he said, which legitimately included within its sphere a number of separate subjects, none of them occupying, however, a more prominent position in the United States, at the time he wrote, than “the proper provision for the custody, care and cure of the insane.”²¹ Yet at about this very time a development was in process which in its far-reaching consequences was to make of psychiatry a specialty in a fuller sense than Pliny Earle envisaged. The development referred to had its beginnings in the years 1867 to 1873; William A. Hammond, of the Bellevue Hospital Medical College, opened “a clinic on nervous diseases and insanity” in 1869, and J. Keating Bauduy, of the St. Louis College of Physicians and Surgeons, opened a similar clinic at St. Vincent Insane Asylum in the same year²², in addition to these, so-called “nerve clinics” for the treatment of nervous disorders were established in Philadelphia in 1867 and in Boston in 1873.²³ But it was not until 1885 that a “dispensary for the free treatment of persons suffering from “incipient mental disease” was opened in the out-patient department of the Pennsylvania Hospital. This service was regarded as experimental, being undertaken “under a conviction that in a city of one million inhabitants, a large number were suffering from premonitory symptoms of insanity as nervous prostration and depression, who might receive kindly advice and treatment, and that a further development of mental disorder might thus be arrested.”²⁴ Not long afterward the State Hospital for the Insane at Warren, Pennsylvania, opened an out-patient

²⁰ *Ibid.*, XXIX (1872-73), 135.

²¹ Pliny Earle, “Prospective Provision for the Insane,” *Am. J. Insanity*, XXV (1868-69), 51.

It is of some interest that the word *psychiatry* was not in very common use throughout at least the first three quarters of the nineteenth century, the term *medical psychology* being much more usual, and this seems to have been even truer of England, where it still tends to be the case, than of America. Indeed, if the *New English Dictionary* is correct, the word, in English, is two years younger than the Association of Medical Superintendents of American Institutions for the Insane, for its first occurrence is given as in Worcester's *Dictionary* of 1846, which cites the *Monthly Review*. But the word existed in German (as *Psychiatrie*) at least as early as 1837, since Friedreich and Blumroeder's *Blatter fur Psychiatrie* was founded in that year. Dunglison's *Medical Lexicon* (1857 edition) contains the words *psychiater* and *psychiatric*, but not *psychiatry*.

²² *Am. J. Insanity*, XXVI (1869-70), 415.

²³ Franklin G. Ebaugh and Charles A. Rymer, *Psychiatry in Medical Education* (New York, The Commonwealth Fund, 1942), p. 5.

²⁴ *Ibid.*, p. 6.

department which functioned two afternoons a month. "From such modest beginnings," write Ebaugh and Rymer, "grew the elaborate and widely utilized out-patient organizations which contribute so materially to our programs of prevention and early and follow-up care, and which form a vital part of the teaching of psychiatry in the clinical years."²⁵ From such modest beginnings there grew—after an incubation period of more than twenty years—particular and indeed intensive interest in the care of sufferers from early mental disorder. This interest found expression in the establishing of observation wards, psychopathic wards, and psychopathic hospitals designed to receive all classes of mental patients for first care, examination, and observation, and to provide short, intensive treatment of incipient, acute, and curable insanity.²⁶ Examples are Pavilion F at Albany (1902), the State Psychopathic Hospital at the University of Michigan (1906), the Boston Psychopathic Hospital (1912), and the Henry Phipps Psychiatric Clinic (1913). This was the evolution which Southard later (1919) called "the outstanding development of the last quarter century of the American Medico-Psychological Association's history."²⁷ Its fundamental significance lay in the fact that it enlarged the sphere of psychiatry to include for the first time an interest in the ambulatory patient suffering from mental disorder.

The end of the decade which saw the establishing in several medical schools of chairs in "medical psychology" was marked by a wider and, so to speak, more official medical recognition of psychiatry as a specialty, in the form of the adoption at the annual meeting of the American Medical Association held in 1870 of a resolution "recommending the medical schools to create a chair for the purpose of affording clinical and didactic instruction on the subject of mental diseases, as a regular branch in the college curriculum." In the following year, at the twenty-fifth annual meeting of the Association of Medical Superintendents, resolutions were adopted favoring "a full course of lectures, didactic and clinical, on insanity, as a requisite for the degree of Doctor of Medicine."²⁸ Yet it was necessary for more than forty years to elapse before these resolutions were carried into more than very partial and incomplete effect—or Graves

²⁵ *Loc. cit.*

²⁶ James V. May, "The Functions of the Psychopathic Hospital," *Am. J. Insanity*, LXXVI (1919-20), 21.

²⁷ E. E. Southard, "Cross-Sections of Mental Hygiene: 1844, 1869, 1894," *Ibid.*, LXXVI (1920-21), 91.

²⁸ John H. Callender, "History and Work of the Association of Medical Superintendents of American Institutions for the Insane," *ibid.*, XL (1883-84), 1.

could not have said, as late as 1914, that "Neurology and psychiatry are unfortunately considered by curriculum makers and the profession generally as belonging to the narrowest and least important of specialties."²⁰ Nevertheless, at the time these seemingly rather sterile resolutions were passed, a beginning had already been made, as we have seen, in the direction of including some little instruction in mental diseases in the medical curriculum; in 1871, the year the resolutions were passed by the Association of Medical Superintendents at its Toronto meeting, lectures in the subject were being delivered in eight medical colleges.²¹ Twenty years later, in 1893, ninety-six medical colleges, or some two thirds of the total number in the country, are stated to have furnished their students "educational facilities in this specialty."²² This fact might seem to indicate the fulfillment of the optimistic prediction made in 1874 that "psychological medicine must soon become, if it is not already, a recognized specialty, as much so as Diseases of the Eye and Ear."²³ That it indicated no such fulfillment is suggested by the fact that as late as 1909 a large group of educators under the sponsorship of the American Medical Association scarcely mentioned psychiatry in a rather extensive discussion of the content of the model medical curriculum; indeed, twelve hours of didactic teaching in the junior year was the total allotted to the teaching of psychiatry and neurology combined.²⁴

Five years later, Graves reported the standard medical curriculum as exhibiting three general defects in the teaching of psychiatry, namely: neurology received much more time and attention than did psychiatry; with the exception of two medical schools, no instruction was given in psychiatry in the third year of the curriculum; and the teaching of both psychiatry and neurology, in fact, was confined for the most part to the fourth year. More directly to the point than these specific details is Graves's broad evaluation of these and other findings, which reads as follows: "Does the standard medical curriculum and do the medical schools of this country allot to neurology and psychiatry time and place propor-

²⁰ William W. Graves, "Some Factors Tending toward Adequate Instruction in Nervous and Mental Diseases," *J A M A*, LXIII (1914), 1707. (Cited by Ebaugh and Rymer, *op. cit.*, page 9.)

²¹ N. Emmons Paine, "Instruction in Psychiatry in American Medical Colleges," *Am. J. Insanity*, L (1893-94), 372.

²² J. B. Andrews, "President's Address," *ibid.*, 55.

²³ R. P. Huger, "Psychological Medicine, Considered as a Specialty," *ibid.*, XXXI (1874-75), 264.

²⁴ Ebaugh and Rymer, *op. cit.*, pp. 13, 14.

tionate to the importance of these branches? . . . It would seem that we are justified in answering the question in the negative when we consider the lack of interest by medical students in the clinical aspects of neurology and psychiatry as contrasted with the definite interest in the anatomy and physiology of the nervous system during the first two years of medical school work, the almost universal feeling of incompetence in the recognition of nervous and mental diseases by recent graduates; the apathy, and I may say indifference, toward the easily discoverable signs of mental and nervous diseases by medical men generally (excepting by those specializing in these branches and not always by these); the ignorance displayed by our courts concerning them; and the existence and growth of the several 'isms' and 'cults' which thrive on the credulous, the unbalanced and the nervous."⁸⁴

It is not without reason, therefore, that from at any rate the standpoint of the development of psychiatric teaching in the United States, Ebaugh and Rymer have called the period of American psychiatry up to 1914 the period of "psychiatry in isolation"⁸⁵—the period of the relative isolation of mental disease from medicine, and of mental hospitals from universities; a period characterized by dominance of the organic point of view, and by a type of teaching which was didactic, descriptive, and "largely in terms of the insanities."

But during the twenty years following upon 1914, and particularly from 1934 onward, there took place a progressive and distinct improvement in the status of psychiatry as a medical specialty—as measured, that is, by the position and importance given to it in the medical school curriculum. For in 1934, some psychiatry was included in all medical schools. Moreover, forty-one schools (out of sixty-seven) offered instruction in psychiatry during the pre-clinical years of the medical course (as against twenty-nine doing so in 1932); this number had grown to forty-eight by 1936, and to fifty-nine by 1940. Furthermore, the average number of pre-clinical hours given to psychiatry in these schools rose from sixteen in 1932 to twenty-six in 1940, and of clinical hours from sixty-five in 1932 to sixty-nine in 1936 and ninety-two in 1940.⁸⁶ Such figures as these speak for themselves and need no comment. But they are even more striking when contrasted with the figures which Graves reported in 1914 on the

⁸⁴ *Ibid.*, pp. 8, 9, quoted from *J A M A.*, LXIII (1914), 1707.

⁸⁵ *Ibid.*, p. 19.

⁸⁶ *Ibid.*, pp. 15–18.

Samuel B. Woodward

1844-1848

Chas. W. News

1873-1879

William M. Smith

1848-1851

Clement A. Walker

1879-1882

Luther V. Bell

1851-1855

Josh. Calender

1882-1883

Isaac Ray

1855-1859

John S. Grant

1883-1884

Andrew M. Farland

1859-1862

Thomas S. Kirkbride

1862-1870

Henry Earle

1884-1885

Mrs. S. Butler

1870-1873

O. Evert

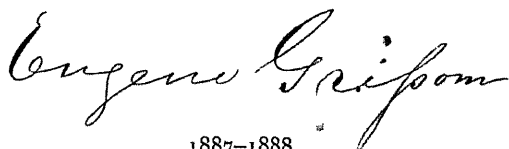
1885-1886



1886-1887



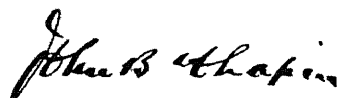
1892-1893



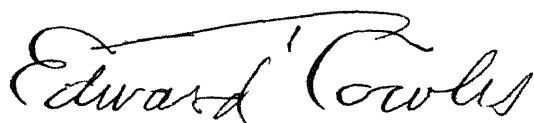
1887-1888



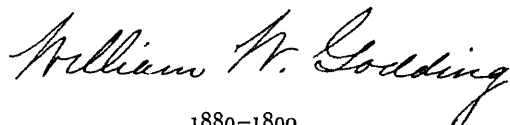
1893-1894



1888-1889



1894-1895



1889-1890



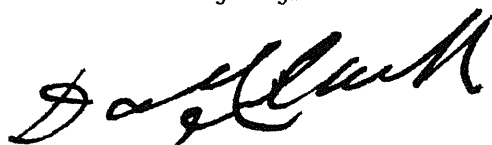
1895-1896



1890-1891



1896-1897



1891-1892



1897-1898

basis of information obtained from the medical school catalogues of eighty-five medical schools in the United States,⁸⁷ to the effect that out of a total of 150 hours assigned in the standard medical curriculum to neurology and psychiatry combined, only thirty were allotted to psychiatry (all of which were to be given in the fourth year), as against sixty hours of neurology in *each* of the third and fourth years.⁸⁸

In this gradual growth, first, in the number of medical schools offering instruction in psychiatry, and second, and much more recently, in the number of hours in the medical curriculum devoted to such instruction, we find the clearest reflection of the development of psychiatry as a specialty—the one standing to the other, indeed, in the relation of both cause and effect. For, obviously, the advance of psychiatry from a position of nonexistence or of comparative insignificance in the medical curriculum to one of conspicuous importance has contributed very measurably to the status of psychiatry as a specialty existing in its own right. It is equally obvious, and of even greater cogency, surely, that this very advance in the importance of psychiatry in the medical school curriculum is a reflection of the recognition of the position of psychiatry as a specialty on its own account.

No single person in the history of American psychiatry has done more to bring about this recognition than Adolf Meyer. His example and his influence have been paramount in the teaching of psychiatry, both undergraduate and graduate; as no less influential has been his leadership in clinical psychiatry, psychiatric research, mental hygiene, and social psychiatry. His conceptions have permeated the whole of modern psychiatric thought. Whatever may justly be said of the contemporaneous

⁸⁷ It is significant that this number had fallen to sixty-seven in 1932.

⁸⁸ The reader is referred in particular to Chapter IV of Ebaugh and Rymer's volume. This chapter describes the survey of psychiatric teaching undertaken in 1932 by the Division of Psychiatric Education of the National Committee for Mental Hygiene. It includes a discussion of the objectives of psychiatric teaching as formulated by those in charge of the teaching program, and a description of the attitudes toward psychiatry found among the deans of medical schools, the professors of medicine, and the professors of pediatrics.

Under the general heading of psychiatric teaching should be mentioned in passing the fact that it was in 1882 that the first training school for nurses in a mental hospital was opened by Dr. Edward Cowles at the McLean Hospital (*Institutional Care of the Insane in the United States and Canada* [Henry M. Hurd, ed.], I, 295-6, cited by Samuel W. Hamilton, Chapter IV of this Volume). In the following year, 1883, a similar training school was established at the Buffalo State Hospital by J. B. Andrews (*Am. J. Insanity*, LI [1894-95], 22). In 1892 there were nineteen such training schools in America (*loc. cit.*).

In this connection mention should be made of C. B. Burr's *A Primer of Psychology and Mental Diseases for Use in Training Schools for Attendants and Nurses*, which reached its third edition in 1906, its fourth edition, as a *Handbook*, in 1914, and a fifth in 1921.

development of broadening medical opportunities, which provided the apparatus and the possibilities for the application and realization of his conceptions and projects, it is still true that, far more than any other single man, Adolf Meyer is responsible for the difference between the form and content of psychiatry as a specialty as we know it today and the specialty of psychiatry of which Pliny Earle spoke in 1868.

At this point may be mentioned two other figures in American psychiatry, whose influence—each in its own entirely separate way, and each as different as possible in both character and scope from that of Adolf Meyer—ranks at not too great a remove from Meyer's in its fruitfulness and in its shaping of present-day American psychiatry as a specialty. The first of these is Thomas W. Salmon (1876–1927), first Director of the National Committee for Mental Hygiene. Foremost among his interests was a better understanding and a closer cooperation between psychiatry and other branches of medicine. It was his faith, it has been said, that increasing knowledge was beginning to elevate psychiatry from the position of neglected step-daughter of medicine—the Cinderella of medicine, in his own phrase—to a place of honor and greater usefulness in the family of medical specialties. His own contribution, and the lasting influence it has exerted, lay principally in the field of what may be called the public health aspects of psychiatry; and to this, as to all he undertook, he brought a practical idealism almost unique and an organizing ability little short of genius—the two vitalized by the power of an extraordinary personality.

The other is A. A. Brill, whose merit it is that in the second decade of the present century he introduced into this country and into American psychiatry the ideas of Freud, initially through the medium of translations of the latter's writings. It should be unnecessary to say that without psychoanalysis, without the most systematized and the most dynamic theory of mental phenomena that we possess, psychiatry could in no way lay claim to the position as a specialty which it has come to occupy. In being the first American psychiatrist to perceive the bearing of Freud's concepts upon the understanding and treatment of certain types of psychiatric patients, and particularly in insisting unremittingly upon the value and importance of this bearing, A. A. Brill has played a part in the present-day configuration of psychiatry as a specialty which should not be underestimated. Next to Adolf Meyer—*facile princeps* in creating American psychiatry as a specialty—should be placed these two, Thomas W. Salmon and A. A. Brill, for their part as leaders in two of the great move-

ments of profound significance for the development of psychiatry which arose shortly after the turn of the century: the mental hygiene movement and the psychoanalytic movement.

The psychiatry of the nineteenth century was largely a psychiatry without psychopathology—meaning by psychopathology the attempt to understand disorder in terms of psychological processes. And psychopathology has mainly grown, not out of the study of the psychoses, in which the clinical phenomena are predominantly mental in character, but out of the investigation of hysteria, in which the clinical manifestations are in great part physical or somatic. The understanding of mental problems in general, in other words, began with the study of hysteria.

But the study of the neuroses—the wide prevalence of which gives them an importance, from the standpoint of the practice of medicine, considerably greater than that of the psychoses—has been a part of American psychiatry in almost wholly a derivative way only. Its foundation was laid with the establishing of the concept of suggestion (by Bertrand in France and by James Braid in England, whose *Neurhypnology* was published in 1843)—the first definite psychological concept contributed to medicine. A further step was taken by Bernheim (1837–1919) of the so-called Nancy school, who held that all the phenomena observed by the old magnetizers of Mesmer's day, by the hypnotists (such as John Elliotson, James Esdaile, James Braid, and others), and by the Charcot group at the Salpêtrière, were the result of suggestion. These views of Bernheim regarding the ubiquitousness of suggestion as an influence and indeed a determining factor in human behavior³⁹ exerted a marked effect upon the subsequent development of psychological medicine, and were certainly responsible for a greatly increased recognition of the incidence and influence of psychological factors in medical practice. Meanwhile, the great neurologist Charcot (1825–1893), teacher of Janet and of Freud, eventually reached the view that certain of the symptoms of hysteria were due to "ideas." Although with this view there was laid the foundation stone of the psychopathological conception of hysteria and the beginning of a delimitation of "psychogenic" from other diseases, it remained for Pierre Janet (1859–) to develop this conception into a full-fledged interpretation of the phenomena of hysteria in psychological terms. To this end he devised the concept of "dissociation of consciousness," at the

³⁹ Bernheim recognized the existence of psychic "automatisms," as he called them—of acts devoid of conscious intent or even conscious origin, which impose themselves upon us through our imitableness and suggestibility—our *crédivité naturelle*, see Zilboorg, *A History of Medical Psychology*, pp. 368, 369.

same time, however, postulating a constitutional weakness of the mind and nervous system, a *dégénérescence*, as underlying the tendency to such dissociation. Morton Prince (1854-1929), author of the famous *Dissociation of a Personality* (1906), founder of the *Journal of Abnormal Psychology* (1906) and of the Harvard Psychological Clinic (1927),⁴⁰ and "pioneer in American psychopathology," who said that "the problem of motivation is the only important one in human life," explored the field opened up by Janet to such effect that it has been said of him that he used the experimental method in psychopathology more consistently than any other investigator.⁴¹ Janet further grouped together, under the rubric of "psychasthenia" (1903), a number of clinical manifestations not definitely hysterical, such as phobias, obsessions, and compulsions, wherein the essential disturbance consisted in a dissociation analogous to that responsible for hysteria, even if differing from the latter in certain respects.

This stage in the history of psychopathology has been compared with the situation in astronomy at the time of Kepler.⁴² Kepler had shown that the planets moved in ellipses around the sun, but he could not explain why they did so. This latter achievement was the work of Sir Isaac Newton, with his formulation of the law of gravity. With the conception that the phenomena observed were the result of certain hypothetical forces interacting in accordance with certain definable laws, Newton added a dynamic conception as a means of understanding the observed sequence of events. A similar advance from a descriptive to a dynamic point of view was necessary to the construction of a psychological conception leading beyond the level reached by suggestion on the one hand and dissociation on the other. This Newtonian step, this dynamic conception, was supplied in the closing years of the last century by Sigmund Freud (1856-1939), neurologist, neuropathologist, and pupil of Charcot, to whom we owe, as has already been said, the most systematized and the most dynamic theory of mental phenomena that we possess.⁴³

The field of the neuroses was the last to be wrested for psychiatry from

⁴⁰ Of which Henry A. Murray, successor to Morton Prince, is the present Director.

⁴¹ Bernard Hart, *Psychopathology; Its Development and Its Place in Medicine* (Cambridge, England, Cambridge University Press, 1927), p. 40.

⁴² Bernard Hart, "The Development of Psychopathology as a Branch of Science," in *Problems of Personality, Studies Presented to Dr. Morton Prince, Pioneer in American Psychopathology*, edited by C. Macfie Campbell et al. (New York, Harcourt, Brace, 1925), p. 237.

⁴³ For a detailed discussion of this important chapter in general psychiatric history, see for example, Pierre Janet, *Psychological Healing* (New York, Macmillan, 1925); Bernard Hart, *Psychopathology; Its Development and Its Place in Medicine*, J. Milne Bramwell, *Hypnotism, Its History, Practice, and Theory* (3d ed., Philadelphia, Lippincott, 1930), Gregory Zilboorg: "The Discovery of Neuroses," Chapter IX of *A History of Medical Psychology*.

the grip of theological condemnation, during the sixteenth and seventeenth centuries, and from an attitude of indifference or of ridicule and contempt, in the eighteenth and nineteenth.⁴⁴ It was Charcot who first threw the weight of his authority on the side of the reality and objectivity of hysterical phenomena, and therewith repeated on a small scale the act of liberation commemorated in the picture of Pinel which adorned the lecture hall of the Salpêtrière.⁴⁵

If the creative contribution of American psychiatry to the evolution just sketched was a relatively insignificant one, this country is nevertheless second to none in that application of psychopathological principles to medical and to social problems which has distinguished American psychiatry of the twentieth century.⁴⁶ Although, for example, the mental hygiene movement and the psychoanalytic movement might appear to have rather little in common, nevertheless the contribution of the latter to the former, no matter how indirect or unapparent, is unquestionable and fundamental. Indeed, in essentially every field of modern psychiatry, psychoanalytic principles—whether avowedly or not—have been implicit. They have been the little leaven which leaveneth the whole lump.

Regarding the course and development of the psychoanalytic movement in the United States, a few bare statements must suffice. It was in 1909 that James Jackson Putnam, the neurologist, and G. Stanley Hall invited Freud to deliver five lectures on psychoanalysis at Clark University, Worcester, on the occasion of the twentieth anniversary of the University's founding.⁴⁷ In the same year A. A. Brill published the first of a number of translations of Freud's works, the *Studien über Hysterie*, under the title *Selected Papers on Hysteria*—followed by translations of *Drei Abhandlungen zur Sexualtheorie* (1910), *Die Traumdeutung* (1913), *Zur Psychopathologie des Alltagslebens* (1914), and still others

⁴⁴ Zilboorg, *op. cit.*, pp. 349, 365.

⁴⁵ Freud, "Charcot," *Collected Papers* (New York and London, International Psychoanalytic Press, 1924), I, 19. For a general survey of the field of psychopathology, the reader is referred to two recent American works, each in its own way of particular merit: J. F. Brown, *The Psychodynamics of Abnormal Behavior* (New York, McGraw-Hill, 1940), and A. H. Maslow and Bela Mittelman, *Principles of Abnormal Psychology, the Dynamics of Psychic Illness* (New York, Harper & Brothers, 1941).

⁴⁶ Dr. Salmon used to emphasize that it was to the social significance of mental disease that this country made its greatest contribution (William A. White, *Twentieth Century Psychiatry* [New York, W. W. Norton, 1936], p. 23).

⁴⁷ Freud, "The Origin and Development of Psychoanalysis," *Am. J. Psychol.*, XXI (1910), 181. It might be noted that J. J. Putnam was sixty-three years of age at this time, and G. Stanley Hall sixty-five!

subsequently. In 1911 the New York Psychoanalytic Society, the first psychoanalytic society in this country, was founded. This was followed, after some years, by the founding of similar societies in Boston (1930), Washington-Baltimore (1930), Chicago (1931), Philadelphia (1937), Topeka (1938), Detroit (1940), and San Francisco (1941). These became constituent societies of the American Psychoanalytic Association, which was founded in 1911, three months after the organization of the New York Psychoanalytic Society. The American Psychoanalytic Association held its first joint annual meeting with the American Psychiatric Association in 1926. Further, the New York Psychoanalytic Institute was established, primarily as a center for teaching, in 1931, and the Chicago Institute for Psychoanalysis in 1932; these were followed by the organization of institutes in Washington-Baltimore, Philadelphia, Detroit, and Topeka in the years 1939-1942. The course and development of psychoanalysis in America owes not a little, it should be added, to the coming to this country over the past ten years of a number of European psychoanalysts—including several of that small company who, since Freud, Abraham, and Ferenczi, have made real contributions to the theory and practice of psychoanalysis.

Charcot, Janet, and Freud were neurologists. They were the men who were almost alone responsible, within the past half-century, for the "discovery of neuroses." Before them, in this country, it was also a neurologist, George M. Beard, who in 1869 described a symptom-complex which he labeled neurasthenia.⁴⁸ Before them, it was a neurologist, S. Weir Mitchell, author of *Fat and Blood* (1877), who became internationally famous through his advocacy and use of the "rest cure" in certain neuropathic states. Before them, too, they were neurologists who in 1882 were among the eight to place themselves in opposition to fifteen other experts and to the authority of John P. Gray in considering Guiteau, the assassin of President Garfield, to be insane.⁴⁹ In a word, it was the neurologists who, with the exception noted earlier in this chapter, first concerned themselves, here as abroad, with the ambulatory sufferer from mental or emotional disorder—who first recognized and dealt with, as mentally ill,

⁴⁸ He appears to have shared this distinction with E. H. Van Deusen, then superintendent of the Michigan State Hospital (See Chapter VI of this volume).

⁴⁹ One of these was E. C. Spitzka; another was William A. Hammond, mentioned earlier in this chapter, founder of the *Quarterly Journal of Psychological Medicine and Medical Jurisprudence* (1867) and author (according to Israel S. Wechsler, *A Textbook of Clinical Neurology* [5th ed., Philadelphia, W. B. Saunders, 1943], p. 791) of the first American treatise on neurology (1871).

patients other than those committed or committable to public institutions.⁶⁰ It was the grossly abnormal behavior of many of these latter which naturally first led to the concept of what constituted mental disorder, and of what accordingly lay within the province of psychiatry. It was the contact of the neurologist with the ambulatory sufferers from "functional" disorders and "nervous" complaints which was responsible for the first partial and sporadic steps toward altering this earlier concept and extending it to include a range of clinical and human phenomena beyond those of the "insanities." Still another neurologist, who took one of the earlier steps in the direction of a closer cooperation between psychiatry and medicine, of a psychological approach to certain medical problems, will be mentioned later.

Indirectly through Freud, more directly through Adolf Meyer, it became the dominating trend of American psychiatry in the twentieth century to place the emphasis on the personality of the sufferer from mental disorder or emotional disturbance. As the late Macfie Campbell has said, "the problem of the psychiatrist was no longer to identify a clinical picture but to get to grips with the actual dynamic situation, to reconstruct in detail the life history, with attention to the sensitizing or conditioning influence of environmental factors, and with due appreciation of the nature of emotional disturbances, of substitutive and evasive reactions, of symbolic expressions, of the various modes of getting satisfaction for the complicated needs of the individual."⁶¹ This general trend of psychiatric thought then led rather naturally to increased interest in the human personality in other settings than that of the clinic only. "Since," —to quote Macfie Campbell once again—"the knowledge of the personality derived from the clinic was valid for the personality in all human relations, psychiatry stepped outside the clinic to survey the field of human relations in general."⁶² This tendency found particular and extensive expression in the mental hygiene movement. Having its inception in the activities of Mr. Clifford W. Beers and its official birth in the formation of the Connecticut Society for Mental Hygiene in 1908 and of the

⁶⁰ That is to say, with a few of those nine to eleven million persons (as of 1940, that is) who fall into the category of those living in the community who, because of mental disease, could be committed to a mental hospital if necessary, and those who by reason of alcoholism, psychoneurosis, epilepsy, etc. belong in the "borderland" of psychiatry (See Stanley Cobb, *Borderlands of Psychiatry* [Cambridge, Harvard University Press, 1943], pp. ix-xiv)

⁶¹ C. Macfie Campbell, *Destiny and Disease in Mental Disorders* (New York, W. W. Norton, 1935), pp. 33, 34.

⁶² *Ibid.*, p. 37.

National Committee for Mental Hygiene in 1909, it had as its original objective the improvement of the care of the "insane" and also the education of the public to a better understanding of the nature of mental disorders and the need for measures looking to their prevention. Under the leadership of Thomas W. Salmon, appointed its medical director in 1912, the National Committee for Mental Hygiene broadened its program to include surveys of the care and treatment of the mentally deficient, as well as of the mentally disordered, and studies in delinquency and the neuroses.

We may now note one of the most significant and practically important phases of the mental hygiene movement, and one of those most characteristic of American psychiatry: the development of the child guidance clinic, which had its origin in 1909, although the term itself was not coined until 1922.⁵³ The emphasis upon the study of the personality here shifted to that of the child, the child who is father of the man. The direct study of the personality of the child became a matter of importance for psychiatry—the study of his instinctive and emotional life, of "his gropings for satisfaction and for a grasp of the outside world, and his urge towards self-expression."⁵⁴ And especially, the futility of studying the individual as an isolated unit, instead of as an integral part of a social group, was less easy to overlook in the case of the child than in that of the adult.

The child guidance clinic has attempted to make "a modest and specific contribution" to the welfare of children by studying and treating patients, by seeking to interest other community agencies in the prevention of behavior and personality disorders in children, and by attempting to reveal to the community, through the first-hand study of individual children, the unmet needs of groups of children. In its correlating of certain resources for the care of children handicapped in personality or behavior, the child guidance clinic represents an effort toward bridging "the gap between a period when delinquency, dependency, and mental disease were attacked single-handed by separate professional groups, and a future in which mental health may be as well guarded at danger points by an integrated social program as physical health begins to be."⁵⁵ The major postulate of the child guidance clinic movement is that behavior prob-

⁵³ George S. Stevenson and Geddes Smith, *Child Guidance Clinics; a Quarter Century of Development* (New York, The Commonwealth Fund, 1934), p. 15.

⁵⁴ C. Macfie Campbell, *op. cit.*, p. 38.

⁵⁵ George S. Stevenson and Geddes Smith, *op. cit.*, pp. 2, 9, 155

lems in childhood arise from a variety of causes and demand a variety of techniques for their solution.⁶⁶

The Chicago Juvenile Psychopathic Institute, founded in 1909 by William Healy under the sponsorship of Mrs. W. F. Dummer, was the pioneer in the field of child guidance clinics, even though in a sense the way had already been blazed by Lightner Witmer's Psychological Clinic, established in 1896 at the University of Pennsylvania. The Juvenile Psychopathic Institute was the first clinic for children in which psychiatric, psychological, and social approaches⁶⁷ were combined.⁶⁷ The first mental hospital clinic to study children in any number was the outpatient department of the Boston Psychopathic Hospital, which accepted children from the time of its opening in 1912, as did the Allentown State Hospital, Pennsylvania, opened in 1915.⁶⁸ In 1921, a program dealing with methods for the prevention of delinquency, and planned to cover a five-year period, was adopted on the recommendation of a committee formed at the request of the Commonwealth Fund. The National Committee for Mental Hygiene then offered a demonstration service to examine and treat problem⁶⁹ children, explain the methods and the value of such a service, and help with the organization of permanent clinics to follow. St. Louis was selected as the site of the first such demonstration, in 1922. With the completion of the eighth demonstration the Commonwealth Fund's original program came to an end. But during that five-year period child guidance clinic service in the United States had increased, partly as a result of that program, approximately fourfold; while at the same time the focus of professional attention had shifted from delinquency and the court to "the more subtle evidences of non-adjustment in the home and school." By 1932, twenty-seven of the fifty most populous cities in the country had full-time clinic service, and 232 whole and part-time child guidance clinics were known to the National Committee for Mental Hygiene. In Minneapolis, Newark, and New York a child guidance clinic was incorporated directly into the public school system.⁶⁹

⁶⁶ *Ibid.*, p. 146.

⁶⁷ *Ibid.*, pp. 15, 17 The Juvenile Psychopathic Institute became in 1917 the Institute for Juvenile Research, its support assumed by the state, and its scope extended to cover the wider field of child guidance in its present-day meaning (Ebaugh and Rymer, *op. cit.*, p. 7)

⁶⁸ Ebaugh and Rymer, *loc. cit.*

⁶⁹ Stevenson and Smith *op. cit.*, pp. 20-47, 128, 167 From the standpoint of the nature of the material dealt with by child guidance clinics, it is of interest that in the six years, 1927-1933, at the Institute for Child Guidance, New York City, the conditions most commonly mentioned by applicants as reasons for bringing a child to the clinic were, in order of fre-

Under the aegis of the child guidance movement there was formed the American Orthopsychiatric Association; its official organ, the *American Journal of Orthopsychiatry*, was founded in 1930 under the editorship of Lawson G. Lowrey.

The significance of child guidance—or better, child psychiatry—in American psychiatry has found definite reflection in psychiatric teaching. The professors of pediatrics interviewed by Ebaugh and Rymer in 1932 felt that an average of 30 per cent, (range, 5 to 75 per cent) of the problems in pediatrics are behavior disorders; but, as of that year, these writers found that in the departments of pediatrics brief formal instruction in the field of child guidance existed in only twelve medical schools.⁶⁰ On the other hand, they state, as of 1940, that several excellent courses in child psychiatry are given throughout the country, adding their opinion that “adequate teaching in this field depends upon cooperation between the departments of psychiatry and pediatrics, and one of the most effective means of teaching child psychiatry is through psychiatrists working in the department of pediatrics.”⁶¹

To the two extremely significant movements in American psychiatry referred to above must now be added a third: psychosomatic medicine—definable broadly as the clinical application of psychopathology to medical problems. The interest in the study and analysis of the personality—already manifesting itself in the penetration of psychiatric methods and approaches into industry and public affairs, into the home, the school,

quency, as follows: disobedience, negativism, stubbornness; rebelliousness; “nervousness”, temper, stealing, truancy, home and school, lying, feeding difficulties; “Does not get along with other children”, retardation in school; enuresis, school failure, speech difficulties, disturbing behavior in school, finger sucking and nail biting, placement, adoption, overactivity, shyness, withdrawal, sleep disturbances, fears; excessive phantasy (Stevenson and Smith, *op. cit.*, footnote, pp. 55, 56).

⁶⁰ The same 1932 survey sought the opinion of these professors of pediatrics concerning the jurisdiction of the pediatrician and the psychiatrist in the field of behavior problems of children; six believed that these problems belonged within the jurisdiction of the psychiatrist, twenty-two assigned them to the pediatrician, and twenty-four thought that they should be handled jointly (Ebaugh and Rymer, *op. cit.*, pp. 124, 125). These authors believe that “ideally pediatricians of the future should assume the major responsibility in caring for the behavior problems of childhood. This will require special training in this field in addition to much better general courses in psychiatry.”

In this connection mention should be made of an excellent booklet of some fifty pages, in which a pediatrician calls the attention of his colleagues to some of their responsibilities regarding the mental hygiene problems of early life. Benjamin Spock and Mabel Huschka, *The Psychological Aspects of Pediatric Practice* (New York, New York State Committee on Mental Hygiene, 1939).

⁶¹ Ebaugh and Rymer, *op. cit.*, pp. 246, 247.

and the college—now led psychiatry into the field of general medicine. For the psychosomatic “movement” recognizes that the personality of the individual and his illness are but different aspects of the same (psychobiological, psychosomatic) unit. Stated otherwise, psychosomatic medicine—a term implying in itself a unity of psyche and soma, in contrast to the age-worn and fallacious distinction between mind and body (the “psycho-physical parallelism” of the last century)—represents the psychobiological approach of Adolf Meyer, not to the psychoses and not to mental disease, but to the disorders lying within the domain of general medicine. Whether termed organismic, psychobiological, or psychosomatic, this approach is to the total personality of the patient, which must be studied simultaneously in its psychic and somatic aspects.⁶² In broad terms, then, the concern of psychosomatic medicine is not only with the disease itself, but with the psychological and characterological setting in which it occurs.

More specifically, the key question involved might be said to be that of “psychogenesis.” That is, can psychological factors give rise to “organic” disease? May they have a place in the chain of causative events which lead to “organic” disease? If so, to what extent is this true, and what are the psychological factors thus involved? Such a possibility has, of course, long been suspected; innumerable clinical data of what Stanley Cobb has called the “I-know-a-case” variety have been reported. The founder of the *American Journal of Insanity*, for example, probably enjoyed no priority in his belief that “in a majority of cases dyspepsia is primarily a disease of the brain and nervous system.”⁶³ This was in 1833.

⁶² Flanders Dunbar, Theodore P. Wolfe, and Janet McK. Rioch, “Psychiatric Aspects of Medical Problems,” *Am J Psychiatry*, XCIII (1936-37), 649.

⁶³ Amariah Brigham *Remarks on the Influence of Mental Cultivation and Mental Excitement upon Health* (2d ed., Boston, Marsh, Capen, & Lyon, 1833), p. 103.

He also said (in 1840). “The influence of mind, of mental emotion, in causing and curing disease [is] altogether too much disregarded by medical men” (Winfred Overholser, Chapter III of this volume).

The preface to William Sweetser’s *Mental Hygiene* (1843) may also be quoted in this connection. “Few, we believe, have formed any adequate estimate of the sum of bodily ills which have their source in the mind”, and this author goes on to speak of the patients “the true origin of whose malady is some inward and rooted sorrow” (Albert Deutsch, Chapter VIII of this volume).

One cannot but recall the dictum of Plato: “So neither ought you to attempt to cure the body without the soul, and this is the reason why the cure of many diseases is unknown to the physicians of Hellas, because they are ignorant of the whole, which ought to be studied also. . . . For this is the great error of our day in the treatment of the human body, that physicians separate the soul from the body” (*Charmides*, 156-157).

Sixty years later we find the neurologist, C. H. Hughes, founder of *The Alienist and Neurologist* (1880), putting forward the view that psychological factors might play a part not only in "dyspepsia" but in grippe, "certain heart affections," and even carcinoma. It was his opinion, moreover, that "as we recognize psychic influence over our physiologic life, over our physical and mental habits, so must we come to acknowledge it more generally in our dealings with disease."⁶⁴ Thus it has long been recognized, if only in a rather vague and impressionistic way, that emotional factors may play a part in the "causation" of "organic" disease, while "scientific" medicine has in general been willing to concede to emotional stress only the role of a precipitating factor—of a shock which, trigger fashion, lets loose the actual symptoms of disease. It is only of recent years that evidence has been forthcoming of the transformation from nerve impulse to tissue change and to lesion. Thus in 1907 Kreibich reported his ability to cause a blister to appear on the skin by hypnosis, and this observation was confirmed by Schindler in 1927.⁶⁵ A phenomenon that can take place on the skin, Cobb has remarked, can reasonably be expected to take place in other tissues which are less accessible to observation.⁶⁶ Of this, indeed, H. G. Wolff and his associates have supplied evidence of a strikingness bordering on the dramatic. Having at their disposal a patient with a gastrostomy of forty-seven years' standing, these workers observed that when the man was anxious and resentful, there was increased motility and acid secretion on the part of the stomach, the gastric mucosa becoming hyperaemic, with the later appearance of small haemorrhages and erosion of the underlying mucosa. In a word, they demonstrated a chain of events beginning with anxiety and conflict and ending with gastric ulcer.⁶⁷ In the meantime, experimental proof that emotions could give rise to physiological changes had been forthcoming in the epochal experiments of Walter B. Cannon, which demonstrated the physiological changes following upon rage and fear.⁶⁸ It is with this

⁶⁴ C. H. Hughes, "The Nervous System in Disease and the Practice of Medicine from a Neurologic Standpoint," *J A M A*, XXII (1894), 897

⁶⁵ Stanley Cobb, *Borderlands of Psychiatry* (Cambridge, Harvard University Press, 1943), p. 152.

⁶⁶ *Ibid*

⁶⁷ S. Wolf and H. G. Wolff, "The Genesis of Peptic Ulcer in Man," *J. A. M. A.*, CXX (1942), 670 (Cited by Stanley Cobb, *op cit.*, p. 153)

⁶⁸ See Walter B. Cannon, *Bodily Changes in Pain, Hunger, Fear, and Rage* (New York, D Appleton, 1915) and also his *The Wisdom of the Body* (New York, W. W. Norton, 1932)

experimental proof that, in the words of Cobb, the modern psychosomatic approach to the study of disease may be said to have begun.⁶⁹

All "psychogenesis," everything that is "psychogenic," lies by definition within the sphere of psychiatry. But it may be noted that there are, in a certain sense, two kinds of "psychogenesis." There are, for example, the physical manifestations of hysteria—which first Braid, one hundred years ago, and then Charcot, fifty years ago, demonstrated to be due to "ideas," a conclusion among the most revolutionary in the history of psychiatry. Here a psychological process is transmuted into a bodily manifestation—but in the special and specific sense, on the one hand, that this takes place predominantly through the central nervous system (rather than through the autonomic or sympathetic), and on the other (as Freud later elaborated), that the physical symptom in question is a symbolic substitute for an unbearable emotion.⁷⁰ But there are also "psychogenic" physical symptoms which are mediated through the autonomic nervous system and involve body systems not under voluntary control. Here the physical symptom is not the *substitutive expression* of a repressed emotion, but appears to be the physiological *accompaniment* of such emotion,⁷¹ the physiological concomitant of a chronic or periodic emotional tension—that is, as in "conversion," of an emotion which is suppressed or repressed.⁷² Into this category probably fall such disorders, for example, as asthma and allergy, arterial hypertension, and gastric ulcer. It is such illnesses as these, which are accompanied by organic changes but of which

⁶⁹ Stanley Cobb, *op. cit.*, p. 154.

⁷⁰ "In hysteria the unbearable idea is rendered innocuous by the quantity of excitation attached to it being transmuted into some bodily form of expression, a process for which I should like to propose the name of *conversion*."—Freud, "The Defence Neuro-Psychoses, an Endeavor to Provide a Psychological Theory of Acquired Hysteria, Many Phobias and Obsessions, and Certain Hallucinatory Psychoses" (1894) (*Collected Papers*, I, 63).

⁷¹ The physiological accompaniment experimentally demonstrated by Cannon

⁷² I know of no clearer statement of the matter than the following "It is not certain that 'psychic factors' are ever 'causative' of 'somatic disturbance' Even in far simpler experimental situations such as Cannon's early observations on the bodily changes which accompany certain emotional states, it is more useful to think of adrenal secretion and sympathetic discharge as being not in 'causative' relation but as somatic manifestations of a process which psychologically we recognize as rage and fear. The rapid cardiac rate associated with anxiety is not *caused by anxiety* but is the *somatic expression* of the same phenomenon which subjectively is experienced as anxiety. Increased cardiac rate does not *cause* anxiety, nor does anxiety *cause* increased cardiac rate This is more than argumentative hair-splitting To make this relation plain seems essential to clear understanding."—Carl Binger, N. W. Ackerman, A. E. Cohn, H. A. Schroeder, and J. M. Steele, *Personality in Arterial Hypertension* (MSS to be published during 1944 by Psychosomatic Medicine Monographs).

the origin is not understood, that are among the major concerns of psychosomatic medicine.

In more general terms, the concern of psychosomatic medicine is with the emotional factors in physical disease.⁷³ Thus, the existence of psychosomatic medicine is due not only to the fundamental physiological experiments of Cannon, but to the disclosure by psychiatry of the fact that every illness has its psychological component—a component which is the concern of psychopathology; “so that in a sense it will be seen that psychiatry is the one medical specialty which in its broadest conception can be regarded as the central point of all medical specialties, for it is only from the standpoint of the psychiatrist, or, perhaps better, from the psychological level, that the significance of disease of the various parts of the body can be understood.”⁷⁴

In this connection, mention should be made of the establishing in 1939 of the journal, *Psychosomatic Medicine* (with the sponsorship of the Committee on Problems of Neurotic Behavior, Division of Anthropology and Psychology, of the National Research Council, and under the editorship of Flanders Dunbar), and also of the American Society for Research in

⁷³ “We have statistics concerning the percentage of persons in any community who, sooner or later, will become inmates of mental hospitals. We have no statistics concerning the percentage of persons in any community who will be handicapped in their recovery from organic illness or made inmates of institutions for the care of the chronically ill, because of the psychic, not primarily the somatic, factor in their disorder”—H. F. Dunbar *et al.*, *op. cit.*, p. 653

⁷⁴ Strecker states “It is not an overstatement to say that fully 50 per cent of the problems of the acute stages of an illness and 75 per cent of the difficulties of convalescence have their primary origin, not in the body, but in the mind of the patient”—H. F. Dunbar *et al.*, *op. cit.*, p. 654, footnote 9

It would certainly be amiss in this connection to fail to mention George Draper, of New York, who with his envisaging of the patient from the standpoint of the four “panels of personality”—the anatomical, the physiological, the immunological, and the psychological—was certainly among the first of American medical men, beginning some twenty years ago, to adopt an attitude toward physical illness which transcended that of traditional medicine, and who should equally certainly be considered one of the outstanding forerunners of the present-day psychosomatic “movement”

⁷⁴ William A. White, *Twentieth Century Psychiatry* (New York, W. W. Norton, 1936), pp. 44, 45.

With reference to the foregoing, the reader is referred in particular to: Flanders Dunbar, *Emotions and Bodily Changes* (2d ed., New York, Columbia University Press, 1938), Franz Alexander, “Fundamental Concepts of Psychosomatic Research: Psychogenesis, Conversion, Specificity,” *Psychosomatic Medicine*, V (1943), 205; Stanley Cobb, *Borderlands of Psychiatry* (Cambridge, Harvard University Press, 1943), Dunbar, *Psychosomatic Diagnosis* (New York, Paul Hoeber, 1943), Henry B. Richardson, *The Patient Has a Family* (New York, The Commonwealth Fund, 1944), especially chapter IV.

Psychosomatic Problems, of which the first meeting was held in May, 1943.⁷⁵

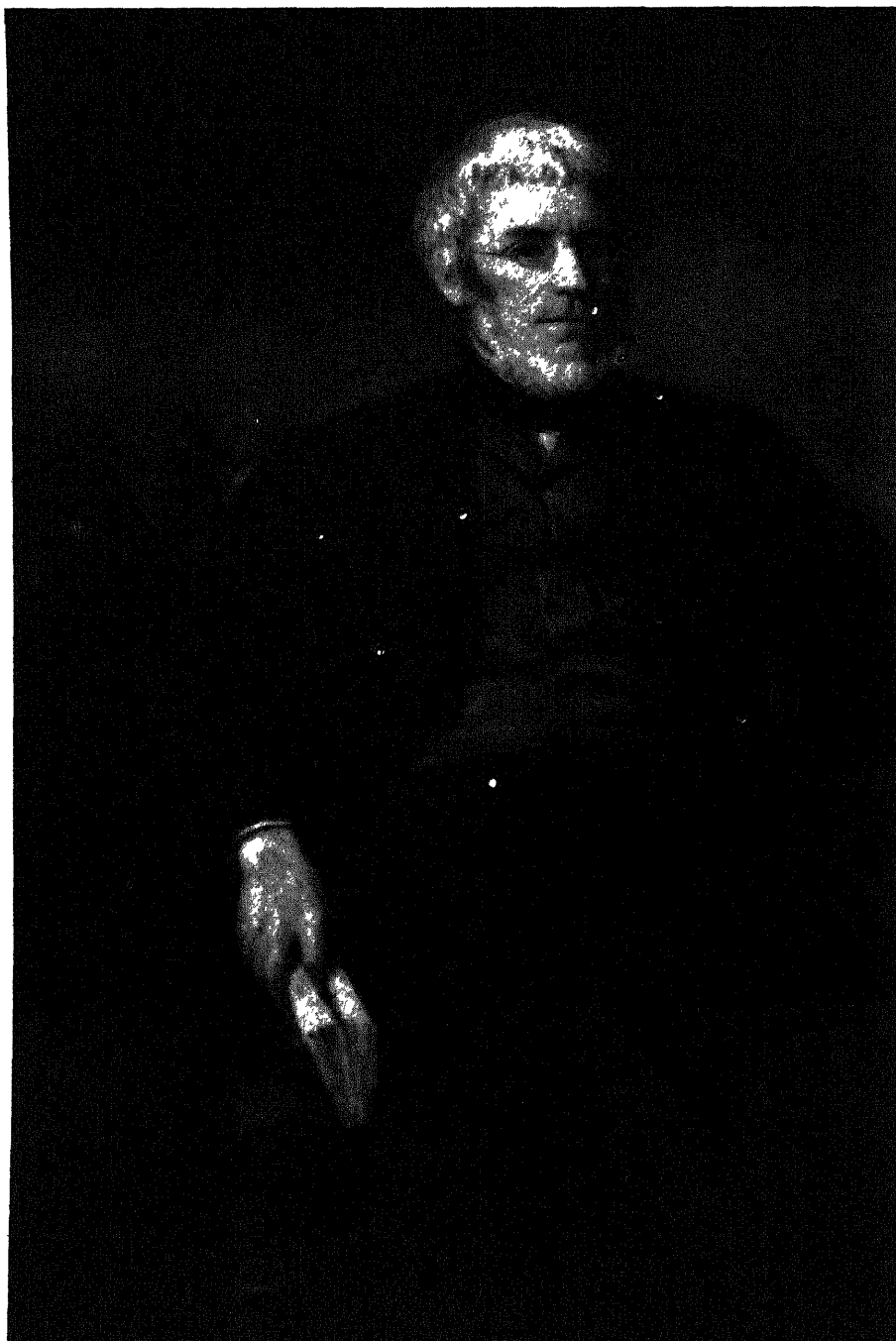
In conclusion, note may be taken of the position of Ebaugh and Rymer, whose *Psychiatry in Medical Education*, so often referred to in this chapter, is conceived throughout in the spirit of "better teaching of psychiatry and the teaching of better psychiatry." "The third fundamental principle," they write, "is the close relationship of psychiatry to medicine in general. It should be constantly reiterated that psychiatry has a vastly broader scope than mental disease. It has a very real part to play in all branches of medicine, and so important is this relatively new aspect of medicine that we believe it cannot fail to permeate in time the whole medical curriculum and the outlook of the entire medical profession toward disease. Psychosomatic medicine is going to be the focus of emphasis in psychiatry, and we must constantly stress the importance of emotional factors in disease. These three fundamentals may come as a surprise to those who believe that psychiatry has to do only with mental disease *per se*. However, as we have repeatedly tried to show, psychiatry must assume responsibility for the consideration of man as a whole, for the recognition of personality factors in somatic disease, and for building the liaisons between psychiatry and general medicine."⁷⁶

We have traced—sketchily enough, to be sure—the evolution of American psychiatry from the days when its essentially sole concern was with the care of the "insane," the days of its more or less complete isolation from medicine, the days when it even lacked the recognition as a specialty accorded to "Diseases of the Eye and Ear"; we have followed, however cursorily, its escape from the narrower field of mental disorders into the broader field of human activities—into the home, the school, the factory, the wards of the general hospital. In this evolution psychiatry has become less and less a specialty, in the ordinary sense—more and more "the central point of all medical specialties." It is not too much to say that, in its actual and potential contribution to general medicine, to education, to sociology, indeed to the general business of living, psychiatry, without claiming omniscience for itself, is cast for a role of fundamental importance in helping to shape any world that may come out of the present

⁷⁵ Honorary President, Adolf Meyer, President, Tracy Putnam, President-Elect, Winfred Overholser, Secretary-Treasurer, Edwin G. Zabriskie

⁷⁶ Ebaugh and Rymer, *op cit*, p. 508

one. If the Black Death and the Great Plague have become things of the forgotten past, it is even possible that some of the destructive forces of the human mind may some day go the same way. If such a hope seems chimerical enough at this present moment, let us remember that on the astronomical time-scale, as Sir James Jeans reminds us, man—although born in a house seventy years old—is himself the merest infant of three days of age, with three score years and ten still to live.



ISAAC RAY

GREGORY ZILBOORG

LEGAL ASPECTS OF PSYCHIATRY

THE history of the problems reviewed in this essay is old, and its psychological as well as cultural continuity has never been broken. History, despite its occasional apparently sudden mutations or silent stretches of seemingly sterile inactivity, never ceases; it never loses its cultural and ideological threads. They serve always as guides toward the understanding of the historical perspective. They tie our present to our past, and our past to our future.

That the relationship between the practice of psychiatry and the law of the land presents a number of features not found in the relationship of the law to any other medical specialty is self-evident. This has not always been so. Even as recently as a little over a century ago, the issues involved were still so confused that neither the jurist nor the psychiatrist was able to define with sufficient clarity either the points of convergence or the lines of divergence. The law was hardly aware that in matters involving abnormal mental conditions it had to consult a psychiatrist; the physician, in so far as he considered himself an expert on mental diseases (for the specialty of psychiatry had not yet been crystallized), began to be rather impatient with the law in so far as it affected situations in which questions of mental disease were involved. As the psychiatrist's knowledge of psychopathology increased, his restlessness grew and so did his need and desire for professional self-assertion. No sooner did medical psychology perceive itself as a budding, self-conscious medical specialty than it also found itself in conflict with the prevailing legal tradition. Psychiatry felt prompted to state its case, and to do so with a challenge and emphasis.

An exquisite example of the early psychiatrist's claiming the right to counsel the lawyer is the letter which Haslam addressed to the Lord Chancellor of England in 1823:

The introduction of the term *unsoundness*, to denote a particular state of disordered mind, which is supposed to differ from idiotcy and lunacy, has been the source of considerable perplexity to medical practitioners; and, in my opinion, opens an avenue for ignorance and injustice. The application of figurative terms, especially when imposed under a loose analogy, and where they might be supplied by words of direct meaning, always tends to error and confusion. . . .

It now only remains to consider the last material sentence, delivered by your

Lordship at this conference, and which to my limited comprehension, appears, in the same breath, to affirm and deny the same position.

"The finding of him incapable of managing his own affairs, is not sufficient to authorize further proceedings, but there must be a finding that he is of *unsound* mind, and unable to manage his affairs:— incapacity to manage his affairs, being considered as *evidence* of unsound mind "

With the citation of this memorable sentence—unadulterated by any comment, I shall conclude this address to your Lordship, submitting at the same time my own impressions on the subject:— that, to search for its correct exposition is reverential to the law. to crave its elucidation from its exalted minister is an act of respectful deference.— this solicitude is increased from the consideration that the written opinion of the medical practitioner is deposed on oath, and that he is examined by the commissioners and jury under the same awful responsibility:— therefore, when the solemnity of that obligation is contemplated, the anxiety for accurate information will scarcely require an apology.¹

Haslam's plea is one of the earliest statements of the psychiatrist's grievance against the jurist's psychiatric contentions, yet it appears quite mature. It explicitly states to jurisprudence that there is a conflict, and a serious one; it does not shrink or veil the issue.

For this conflict to be so well defined, or so outspoken at any rate, some one hundred and twenty years ago, it must have existed for a long time before Haslam deemed it wise to write to the Lord Chancellor. It did, of course. For many centuries of medical history it had more and more persistently knocked at the heavy armor of tradition and prejudice, until that armor was finally corroded.

The history of this conflict between psychiatry and the law is long and dark and painful, and through great spans of time even tragic; it is not to be recounted here. What is to be established as a point for reflection is that the conflict *has* a history which was lived and written about and often dearly paid for by psychiatrists, who almost alone in medicine bore the brunt of the burden of growth and elucidation of the problems which are covered by the term, "medical jurisprudence of insanity."

Medical jurisprudence is traditionally dated from Paulus Zacchias (1584–1659), who is considered the father of this branch of medical knowledge. But in matters psychiatric Zacchias was rather backward. The legal problems arising in connection with abnormal mental conditions did

¹ John Haslam, *A Letter to the Right Honorable the Lord Chancellor on the Nature and Interpretation of Unsoundness of Mind and Imbecility of Intellect* (London, R. Hunter, 1823), pp 9–10, 31–32.

not seem to him of particular interest, and in so far as he did touch upon them he followed the traditional spirit of witch-hunting and witch-burning. Yet one of Zacchias' predecessors of almost a century earlier proved much more perspicacious and advanced. Cornelius Agrippa (1486-1535) may be rightly considered the founder of the medical jurisprudence of insanity; he established a revolutionary precedent when he, as both lawyer and physician, stood before the court of the city of Metz and raised his passionate voice against the condemnation of an aged woman who was haled to the bar as a criminal, a witch.

Agrippa was both a jurist and a medical man; consequently, his defense of a person on the grounds of insanity might in some measure be ascribed to his legal knowledge. But Agrippa's pupil Johan Weyer (1515-1588), who was a physician only, challenged the existing laws and defended the mentally ill in the name of psychological medicine only. He may be considered the first to have asserted that the opinion of the psychiatrist should in certain cases be considered more valid than that of the jurist. As a matter of fact, by word and action Weyer asserted even more; he challenged the very foundations of the penal code, and he claimed that many of the criminals of his time needed treatment and not punishment, care in a doctor's home and not disposal in a prison, on the gallows, or at the stake.² All this was four hundred years before William A. White and Bernard Glueck in America propounded similar ideas and, it must be admitted, with the same lack of success.

Weyer's claims were not met with favor, the lawgiver sharply denied him the right, as he denied any physician the right, to set his medical opinion above that of the law in matters of mental pathology in relation to crime. The Saxon Code of 1572 plainly counseled that Weyer's views be disregarded: "Weyer is not a lawyer, but a physician—consequently, his views on the relationship between mental disease and transgression of the written law are of no moment." The lawyer in private practice was even more harsh than some of the learned jurists who codified the penal laws of the time. Jean Bodin (1530-1596) was vituperative and venomous for fear that this first intrusion of psychiatry into the business of legal justice might let a host of responsible miscreants go unpunished, with all the dire consequences therefrom made inevitable.

It is easily seen that the conflict between law and psychiatry had reached

² For sources, cf. the writer's *History of Medical Psychology* (New York, W. W. Norton, 1941), pp. 206-235.

a high degree of crystallization almost three hundred years before Haslam. Yet despite its obvious acuteness, the resolution of this conflict has not yet been achieved.

The voice of Weyer, while historically significant, was almost a lone voice. So was that of Jerome Cardan, who some years before Weyer suggested the concept of what we would call today "psychopathic personality," or "irresistible impulse." One of Cardan's sons did not get along with his wife, and he killed her; he paid the supreme penalty. Cardan proceeded then to argue that certain psychopathies should exempt one from legal responsibility.

All these sound psychiatric ideas, so old and yet so familiar to the contemporary psychiatrist and so much his own, clearly suggest that throughout the history of the specialty the psychiatrist has been striving through his special knowledge to gain and to convey enlightenment about the nature of human affairs, and to gain the right to change some of those written regulations whose adherents claim sole right to be the watchdogs and managers of these human affairs.

Since the psychiatrist asserts his ambitious claim not on the basis of some abstract principle but on the basis of actual, special knowledge which he possesses and which the jurist does not, the impression is not infrequently gained that the psychiatrist is more self-righteous than he has cause to be, and that the lawyer possesses more legal than moral and scientific right to assert his disregard of psychiatric knowledge. The atmosphere at the point of contact of these two branches of social endeavor is definitely charged with considerable dissension. This has been true for so many centuries that one is tempted to think of it as in the nature of things sanctified by tradition—and therefore inalienable. However, the development of both psychiatry and jurisprudence and their growing interrelation during the past century tend to confute one's momentary pessimism. The only true regret one would be justified in voicing, and this regret is general among contemporary psychiatrists, is that the evolution of the influence of psychiatry upon legal justice has been and is entirely too slow to be as beneficial as it could be. To the jurist the psychiatrist appears entirely too energetic in his invasion of the field of the law, and to the psychiatrist the jurist appears too complacent and too refractory to the wisdom and humanitarian aspirations which continue to grow with the growth of psychiatry.

Only a proper historical perspective will reduce the asperity of this

relationship and make it more productive. This historical perspective would at once reveal to us that human affairs, whether in the atmosphere of mental health or mental disease, have always claimed the attention of both the jurist and the doctor. These affairs had to be managed, regulated, and otherwise ordered long before psychiatry was born, long before man had any conception that the human mind could become diseased and human behavior pathological as a result of this disease.

The lawyer came first; it was he, and not the physician, who had to manage the consequences of mental disease in so far as they affected the interests of the community. The lawyer then was the first who had to see to it that the psychotic disturber of peace be taken out of circulation, that the homicidal maniac (or criminal insane) be removed from the community and isolated somewhere, that property mismanaged or abandoned by a person mentally deranged be taken care of in some normal, legitimate way. In other words, all the problems which have preoccupied psychiatry ever since it was born existed to the full extent of their urgency before it was born. Attempts at their practical solution were made, precedents established, traditions developed, without benefit of any scientific, clinical psychopathology, the very possibility of the development of such a psychopathology could not even be fathomed many centuries ago.

The problems which we of today consider preëminently psychiatric had been imposing themselves on the community with the constant impact of repetitive demands for a solution. The problems themselves forced *ad hoc* measures; these in turn accumulated in number and were sanctified by current religious belief or superstition, by current morality and other cultural factors finally developing into that unwritten body of jurisprudence known as common law. When the psychiatrist came upon the scene of public life, he was confronted with this massive power of common law to which had been added centuries of spoken and written and codified principles elaborating or simplifying the older procedures.

From the standpoint of the general historical perspective, it is not difficult to see that the psychology of the relationship between the law and psychiatry has always been rather complex and not always conducive to serene and peaceful understanding. Two major characteristics inherent in the psychology of this relationship can be discerned.

The first is rooted in the fact that the psychiatrist is not only a psychiatrist but also a citizen of his community who, like the lawgiver or

the law officer, is concerned with the proper protection of the common weal, and who is himself steeped in the traditions of this community with all its failings and prejudices and more positive trends.

The second feature of the psychiatrist's attitude which is psychologically inherent in the history of the problem is this: Inspired and armed with new knowledge, the psychiatrist becomes a humanitarian reformer and as such is always thrown into inevitable conflict with the old traditions of the law.

Therefore, depending upon circumstances, the psychiatrist is either a servant of the law, its loyal helper, or a rebel who wishes certain laws and legal practices abolished as useless and even injurious, offensive to psychiatric common sense and to the ultimate good of man and his community.

If we view the interrelations between psychiatry and the law from the standpoint of this their double aspect, considerable light may be shed on the true nature of the whole problem, and its history will become more intelligible. It would be a mistake, of course, to assume that these two aspects of the psychiatrist's attitude toward the laws regulating human affairs in so far as they touch the phenomenon of mental disease are clearly defined within psychiatry itself. The contrary is probably more true, or has been true for many years.

Instead of always clearly differentiating for himself the situations in which he was a servant of the law and those in which he challenged its psychological, humanitarian, and sociological validity, the psychiatrist, through his own experience and education, only gradually evolved his attitude. The true criterion of his scientific evolution is to be found only in the psychiatrist's attitude toward mental disease and the degree to which he is guided by the therapeutic intent, which is the essential characteristic and mainspring of all branches of medicine.

Let us take as an example the problem involved in determining the validity of a will when the testamentary capacity of a deceased testator is questioned. The court or the contesting sides dealing with the problem may call for an expert psychiatric opinion. The psychiatrist who undertakes to form an opinion in a case of this nature will appear in court not as a physician, not to help to cure someone or to prevent someone from contracting an illness, but as a citizen who possesses certain special knowledge which the law does not possess but which the law is willing to buy and to use. The psychiatrist testifying in such a case is then merely a

skilled worker, a technician like an engineer, chemist, or electrician. His interest in the case may be enhanced consciously or unconsciously by his civic aspiration to see no one's property foolishly squandered or unjustly distributed. He may also be motivated by pride in his science and profession and a wish to correct certain naive misconceptions which the law has about mental disease.

However, in the last analysis all the above-mentioned motivations are but coincidental and secondary. The psychiatrist in such a case is at best a skilled worker making an honest living, and at worst the willing servant of a law which is after all protecting certain fundamental, ethical principles dealing with property rights. There is no conflict between the law and psychiatry here. These two agencies meeting before the bar treat one another with coöperative respect—in principle at least.

On the other hand, when in the opinion of a psychiatrist a given individual should be placed under psychiatric surveillance and treatment in a hospital and when the law through prosecuting attorney, court, and jury happens to dissent; there is a serious conflict. The psychiatrist is convinced that he is right; his knowledge and his experience support his conviction with all the force of fact. Yet he has no power whatsoever. The law on the other hand may be wrong both scientifically and empirically, as it frequently is; yet it possesses all the power to act as it deems necessary.

That the answer to the question as to the presence and degree of mental disease should at all be entrusted to the law or to an impaneled group of uninitiated laymen does in itself appear to be thoroughly illogical to the contemporary psychiatric mind. Yet the principle is still valid today in certain states of the Union (Illinois, for instance, among others); the law has still the right through some of its agencies alone to determine what amounts to a diagnosis of mental disease. The psychiatrist in such cases, although the sole scientific authority on the subject, is considered only one of the witnesses—that is, a servant of the apparatus of the law, whose judgment and service may or may not be disregarded. If they are disregarded, no legal principle will be violated thereby.

It is obvious that the psychiatrist as a citizen and as a doctor who wished to help and treat a given patient might find himself in sharp conflict with the prevailing views of the community and the law in such matters. The psychiatrist might insist that the community be protected and the individual in question be committed to a hospital, that the patient should be

protected and cured and for this reason should be committed to a hospital. But the law, which for so many centuries functioned in such matters without benefit of psychiatric knowledge, naturally at first looked with considerable suspicion upon those who intruded into the domain of its prerogatives, and the resulting conflict seemed insolvable.

That this conflict did not actually prove insolvable is common knowledge; the history of the development of our laws of commitment bears ample testimony to this fact. As is well known, after a comparatively short period both the demands of clinical psychiatry and those of the law evolved a series of adjustments of their various differences—in a manner on the whole rather satisfactory. The psychiatrist came to be treated by the community and by the law as an experienced, expedient, and judicious servant of the law and the common weal.

But here the rather serene adjustment of differences seems to end. When the problem of mental disease as related to crime, particularly capital crime, arises, the law appears irreconcilable. It insists that it is the only authority to pass on and to define what insanity and its relation to man's responsibility before the law are. And the psychiatrist, even like Weyer almost four hundred years ago, voices the claim to be sole scientific authority in defining and diagnosing mental disease, and further insists that the law is in no position to make any diagnosis and possesses no scientific right to function on the basis of a psychopathology of its own creation.

The history of this conflict is the history of the medical jurisprudence of insanity, for it is around this conflict that we find all the constellations of psychological, scientific, sociological, and cultural contradictions which have accumulated through the ages of human social life, all the isomeres of prejudice and bigotry and hate which are brought into play when man becomes a felon, and finally all the anxiety which society experiences when scientific knowledge calls upon man to be objective in the face of the most destructive aspects of human nature. Society seems to be afraid even to forgive a sin, particularly when science declines to accuse.

One hundred years ago, at the time the Original Thirteen^a foregathered to found what later became the American Psychiatric Association, the problems just sketched above stood out almost as prominently as they do today, and in some respects with equal acuteness. The psychological and scientific trends involved in the consideration of these problems de-

^a See Dr. Overholser's chapter in this volume.

lineated themselves from the outset; medical jurisprudence of insanity was one of the important topics at the first scientific meeting of the Association of Medical Superintendents of American Institutions for the Insane. The young but already authoritative figure of Isaac Ray stood out as the first progressive, combative, and yet very dignified dissenter from the ancient traditions which still prevailed in the law books, at the bar, and among the pioneer psychiatrists themselves. Isaac Ray's voice was to be heard with particular incisiveness for almost forty years to come.

The first volume of the *American Journal of Insanity* published a serious paper on the subject of medical jurisprudence of insanity—from the pen of Dr. C. B. Coventry, "Professor of Medical Jurisprudence in the Medical Institution of Geneva College."⁴ Here Dr. Coventry gives, for the first time in an American medical publication, I believe, the answers of the fifteen English judges to the questions addressed to them by the House of Lords in connection with the McNaghten case. Dr. Coventry discusses briefly but pointedly the question of moral insanity, which he apparently understood primarily as the presence of an irresistible impulse, and is obviously regretful that the fifteen English jurists failed to take into consideration the existence of moral insanity. He even mentions some specific odor which insane persons allegedly emanate, possible sleep disturbances, and initial changes in the pulse rate as signs of mental disease—as if to say that the answers in the McNaghten case failed to consider certain essential aspects of mental disease and disregarded the fundamental principles of clinical psychiatry.

The jurists of McNaghten fame established a set of legal principles and criteria. They seem to have conceived of insanity as a mental category, as a certain definite state, that it was a disease was perhaps implied but not properly emphasized—for the legal mind is not wont to think in terms of pathology. It was the physician's task to emphasize the pathological aspects of insanity in relation to crime; morbid in the legal or lay sense might well mean not more than bad, or depraved, but in the medical sense it had but one meaning—that of disease. That is why even some of the seemingly naïve references to an alleged specific odor of the insane, their pulse rate, or rate of sleep are significant as accentuating the idea of disease, treatment, and cure, and not depravity, arrest, and punishment. Testifying in a case of murder at approximately the time Coventry was composing his paper, Isaac Ray, then superintendent of

⁴ *Am. J. Insanity*, I (1844-45), 134-144.

the Maine State Hospital, agreed with the testimony of Drs. Bell and Woodward, who considered the defendant insane, and added: "In regard to the physical symptoms, I should say that these showed that something was the matter with the man. The state of his pulse, his coated tongue, and shrunken features, plainly showed that he was diseased in some way."⁵

Whatever the differences in medico-legal orientation which existed among the American psychiatrists of 1844—and differences there were, of course—there was general agreement as to the importance of stressing before the court that an insane defendant is a sick man—an assertion which in those days, strange as it may seem, appeared to the American jurist much less contentious and censorious than it appears to many representatives of the law today. One may even say that at the beginning—that is, at the time the thirteen medical superintendents through the founding of their association made the first official step in America to establish psychiatry as a separate medical specialty—the law and the newly born specialty treated one another with considerable respect and with harmonious recognition of scientific authority. The heat of reciprocal fault-finding so frequent in our courts of today and so familiar to psychiatrists who appear as expert witnesses seems to be a much later development. The psychiatrist was not at first inclined to challenge the lawyer's psychiatry, nor did the court seem inclined to question too much the psychiatrist's motives. The abstract, non-clinical if not anti-clinical sophistry of "the McNaghten rule" was but one year old; it had not yet taken hold on the minds of those American jurists who were later to embody this rule in the penal codes of the majority of, if not all, the states.

Samuel Woodward, the first president of the Association, published an essay in the first issue of the *Journal* on the "Homicidal Impulse,"⁶ which he described with quiet detachment rather than with the feeling that he had to defend his point of view against its anticipated rejection by legal authorities. In the case of Rogers, who had killed a prison warden, Woodward appeared as an expert witness and testified to the effect that the murder was committed under the influence of an irresistible impulse.⁷ Instead of being challenged he was upheld by the court, which

⁵ *Ibid.*, p. 268.

⁶ *Ibid.*, pp. 323-326.

⁷ *Ibid.*, p. 267.

agreed that such an impulse does exist, that its presence is a sign of insanity, and that it therefore constitutes a bar to punishment.

The editors of the *Journal* defended their clinical and scientific position in relation to the criminal law with apparent serenity and comfort; the views of some of their contemporary English brethren they found unnecessarily harsh and therefore unacceptable. Commenting on Taylor's *Manual of Medical Jurisprudence*, which had appeared in 1844, the editors took the author to task for devoting but a few pages to the problem of insanity. They disagreed with much of the little Taylor had to say on the subject, and particularly with his contention that "the defense of insanity is carried too far." "We," said the *Journal* editorially, "rather adhere to the opinion of Georget, Marc, Prichard, and others, who have devoted their lives to the study of Insanity, that the plea is not so often successfully made, as it ought to be, and that many deplorable madmen have perished on the scaffold."⁸

And speaking on Thomas Coutts Morrison's essay *On the Distinction between Crime and Insanity*, which was awarded a premium of twenty guineas by the (English) Society for Improving the Condition of the Insane, the *Journal's* reviewer is quite complimentary: "The author next treats of insanity without delusion, or without the intellect being affected. Such a form of madness he believes to exist, and complains of the defect of the law in not recognizing it." The reviewer further picks out certain lines, prefacing them by saying that "the following is a fair hit at the law's infallibility": "If we go into any of our courts of law where a case of lunacy is pending, we find that the law, as laid down by Hale and others, is quoted as infallible; were a case of juggling imposture brought before the same court, would the same reliance be placed upon Hale's opinions respecting witchcraft?"⁹

The psychiatrist of 1844 had not set aside his critical attitude toward the superannuated traditions of the law which had lost their meaning in the light of scientific progress, but at the same time he was not yet fully aware of his conflict with some of the tenacity of legal tradition. Coventry's essay is illustrative and characteristic of this spirit of confidence with which the psychiatrist of one hundred years ago stepped on the new platform of his specialty and beckoned to the law for cooperation. Coventry was fully aware that "notwithstanding all the tact and all the sagacity

⁸ *Ibid*, p. 282.

⁹ *Ibid*, pp. 372-373

and all the learning of the legal profession, the jurisprudence of Insanity remains in the present day about where it was left by Blackstone and Lord Coke"¹⁰—and we may add for our part that the views of Blackstone respecting insanity and crime reflected but the views of Lord Hale, the learned and harsh jurist of the seventeenth century.

Coventry goes on to remind us that the law would not arraign a man for a capital offense, if he became insane; it would not try him, if he lost his senses before trial; it would not sentence him, if he lost his mind before sentence was to be pronounced; it would stay punishment, if a previously sane criminal became insane before the punishment could be carried out. "These provisions of the law," remarks Coventry with obvious satisfaction, "are certainly very merciful, and founded upon the principle on which all penal laws should be founded, viz.: that of preventing crime, not of vengeance by way of retaliation on the person of the criminal."¹¹ This last remark may well appear to a contemporary psychiatrist rather premature and complacent. William A. White's views asserting just the contrary and voiced some eighty years later¹² would seem to confute Dr. Coventry's benevolent confidence in the psychology of the criminal law.

In the light of what we have learned since the days of Dr. Coventry, it is certainly difficult to overlook the trends of vengeance and retaliation underlying the system of legal punishment. It is difficult to suppose that a law demanding that a condemned man awaiting execution must first gain his senses fully before he is led to the electric chair or scaffold is motivated by humane, merciful considerations.

It was not lack of psychological insight or want of cultural attainment that made the psychiatrist of 1844, so well exemplified in the person of Coventry, overlook the motif of revenge in the criminal law. There is little doubt that he fully understood that the law always wished to exact the maximum penalty. The psychiatrist agreed therefore that the machinery of carrying out justice should wait until the accused regained his senses, so that not only would he be able to defend himself at his trial but also, when in full possession of his senses, he would be able to experience the full weight of anguish in meeting his legal annihilation. For in those days, as in so many quarters even today, the belief was widespread that

¹⁰ *Ibid.*, p. 134

¹¹ *Ibid.*, p. 135

¹² William A. White, *Insanity and the Criminal Law* (New York, Macmillan, 1923)

suffering is a deterrent of crime. That the execution of the criminal certainly does not serve the goal of prevention of crime as far as the executed criminal is concerned, and that therefore it makes no difference whether the condemned is sane or insane when he is marched to the gallows, was a thought as yet not fathomed by the citizen of the first half of the nineteenth century. That it might perhaps be even more merciful to execute the criminal while his senses were lost, since in that state he might suffer much less the agony of being legally murdered, would have appeared a preposterous thought to the psychiatric contemporaries of Dr. Coventry. At that time, when American psychiatry was being officially born as a specialty, the old, sentimentalized, legal vengeance and the new humanitarianism of a new medical discipline were still blended into one stream of thought—as clear in its humanitarian aspiration as it was as yet unclear in its rational, scientific basis for a psychological sociology and penology.

What marks the period of psychiatric beginnings is the spirit of co-operative respect between psychiatry and the law as it stood and grew in the ancient soil of tradition. It may not have been universal but it was widespread, this spirit of coöperation which was not erring. Authoritative quarters of the law reciprocated. Chief Justice Shaw of the Commonwealth of Massachusetts, in charging the jury in the above-mentioned case of Rogers, described “the irresistible and uncontrollable impulse” in terms of good understanding. This impulse, once its presence was established in a given case, exempted the defendant from responsibility. As to expert testimony, which in the Rogers case was presented by three of the Original Thirteen (Woodward, Bell, and Ray), one of whom was the first president of the Association, Justice Shaw had this to say to the jury: “The opinions of professional men on a question of this description are competent evidence, and in many cases are entitled to great consideration and respect. The rule of the law, on which this proof of the opinion of witnesses, who know nothing of the actual facts of the case, is founded, is not peculiar to medical testimony, but is a general rule, applicable to all cases, when the question is one depending on skill and science, in any peculiar department.”¹⁸

Thus an enlightened judge of one hundred years ago. The impassioned objections which psychiatry later raised against the hypothetical question (William A. White poignantly called it a monstrosity) and the welter of logical and psychological difficulties with which this question

¹⁸ *Am J Insanity*, I (1844-45), 270.

has become entangled would certainly have never arisen had legal practice and procedure followed the penetrating foresight of Justice Shaw.

Shaw was not alone in propounding the basic medico-legal principles of the theory of the irresistible impulse; Judge Gibson in Pennsylvania, Judge Edmonds of New Jersey, and a few others followed the same trend in their charges to juries or in their decisions.

The remarkable contrast between the cooperative understanding as reflected in Justice Shaw's charge to the jury in the Rogers' case, and the subsequent acrimony, suspicion, and legalistic confusion which have developed in the course of the past century around the problem of crime and insanity is not easy to explain. In England at this period passions had been running high in connection with the same problem. The legal profession there was as conservative on the subject as it is today (we may count Erskine of some half century before that time as an exception). Tradition clung to Lord Hale's ancient views and resisted any medico-psychological innovations. English common law was the foundation of the American law, but the written laws or verbal legal discussions dealing with such special issues as insanity in relation to crime were of comparatively late origin. These did not even begin to become crystallized in England until the latter part of the seventeenth century, when Hale's *Pleas of the Crown* laid the foundation of most of what Blackstone found to say on the subject under discussion. A considerable amount of psychological and sociological independence on the part of the early settlers made it possible for the American attitude to develop gradually, without the heavy load of Hale's tradition affecting it too much. Why American jurisprudence respecting insanity in its relation to crime should in later years have recaptured the Hale, Blackstone, and Coke backward tradition is difficult to tell and is a question beyond the scope of this essay.

There is no doubt that the American founders of the specialty of psychiatry were ready to adopt every liberal thought which came from Europe touching the subject under discussion, and they were rather refractory to and suspicious of the older trends which sprang from Lord Hale. They read and admired Esquirol; the brilliant young Georget, who died too soon but who left a medico-legal heritage not to be forgotten; and last but not least Prichard, who in 1835 published *A Treatise on Insanity and Other Disorders Affecting the Mind*. It was in this treatise that Prichard first introduced the concept of moral insanity.

In those days the opinions of legal authorities on insanity apparently did not carry so much weight in America as they did in England.

To return for one more moment to Coventry's article, the first on the subject of medical jurisprudence of insanity to appear after the founding of the Association of Medical Superintendents of the American Institutions for the Insane, we may note that Coventry classified "the forms in which insanity becomes the subject of legal investigation" as follows:

1. The plea of insanity as a bar to punishment in criminal prosecution.
2. The propriety of confinement when danger to the individual himself or to others is apprehended.
3. The capacity and right of an insane person, or one supposed to be insane, of managing his own affairs.
4. The state of mind necessary to constitute a valid will.

Coventry's principle of classification is obviously sound; it well stood the test of time and will be adopted here. However, the order in which Coventry placed the problems, which is again very sound since it follows the order of diminishing complexity and seriousness of the problem, will be here reversed. This will simplify the presentation which follows and will bring the first things last without prejudice to their importance.

Our order therefore will be this:

1. Problems of testamentary capacity
2. Problems of managing one's own affairs
3. Problems of commitment
4. Criminological problems.

The above sequence will at a glance reveal that the first two rubrics represent psychiatric problems only indirectly, or technically if you will. For if a person is of unsound mind and if this unsoundness of mind makes his last will and testament of questionable validity, or if he enters contractual obligations which he would not have entered if he had been in full possession of his senses, it is the law that is primarily concerned in rectifying the wrong which might ensue as a result of these acts. The psychiatrist, as a physician whose job it is to treat or to prevent mental illness, is not at all concerned with the ensuing wrong or the legal validity of the acts of a person already dead, or of a person living but not under the care of a psychiatrist. The concern of the psychiatrist with testamentary or contractual capacity is limited by the eventuality of a law suit; the contending parties or the court might then, as they frequently do, invite the

psychiatrist as a skilled worker, an expert technician who becomes an added tool in the machinery of the administration of the law. Moreover, the problems involved in such cases are problems of property—property distribution and property rights. In other words, they are economic problems characteristic of a civilization the cornerstones of which are property rights—their acquisition, retention, and possible loss under certain properly defined circumstances.

In such cases we deal not with legal aspects of psychiatry in the strict sense of the term but with psychiatric, technical adjuvants to the administration of the law. As civilization progresses and our technology develops, the law utilizes our technological progress and seeks to put it at the service of administering the law, with the added refinement which the newer techniques afford. In other words, in a review of the legal aspects of psychiatry one might pass over the problems of testamentary or contractual capacity without any injury done to psychiatry in its relation to the law. However, from the point of view of the history of our specialty, these matters deserve more than passing mention. The founders of the Association, as proselytes and zealots in a new field, from the very outset sought to assert the validity of their new-born science as well as to test its ingenuity and perspicacity in every possible walk of life or aspect of human relations. The founders of the Association were broad in their outlook and generous in their interests; they also felt that their concern as psychiatrists was humanitarian in relation to the mentally sick as well as to society and to the healthy who happened to suffer spiritually or materially from the mental sickness of others.

As the reviewer of several treatises on medical jurisprudence put it in 1845: "The *living*, in some cases, should be regarded with as much *justice* as the *last wishes of the dead*."¹⁴

There was another reason for this interest in the purely legal problem of the "responsibility of the insane for civil acts." The budding specialty of psychiatry was early awakened to study with critical curiosity the double standard inherent in the law's treatment of insanity. It was quick to discover and as quick to question whether it is sound to admit, as the law does, the existence of two insanities, one recognized by the civil, the other by the penal code. Reviewing the case of a contested will in the State of Maryland, the *Journal of Insanity* cited the June, 1853, issue of the *United States Monthly Law Magazine* and recapitulated the major

¹⁴ *Am. J. Insanity*, II (1845-46), 88.

points in the case of *Townshend vs. Townshend*. "The principal issue in this case, was whether John Townshend deceased, was at the time of signing his will, of sound mind and capable of making it." John Townshend had claimed that "he had frequent personal interviews and conversations with God Almighty, and was accustomed to receive immediately from God, directions, instructions and commands, in relation to what he should do, and what he should not do. . . We do not care to mention the blasphemies cited in the other specifications, and will only add that it was proved, that Townshend stated that God had repeatedly commanded him to set all his negroes free and give them all his property—that of the will now in dispute, he had said, it was not his own will, but God's will, etc."¹⁵

The decision of the jury was in favor of the will, and on appeal this decision was sustained. Commented the *Journal* "With all due humility, we ask this question: If whether John Townshend had killed a person, his *sanity*, would with the above testimony, have ever been acknowledged? Certainly not. And here, as we have elsewhere remarked, there is a remarkable distinction taken between civil and criminal cases in this respect. Still the decision is usually with juries, and of course we can only anticipate a continuance of the diversity.

"There is, however, one point in the biography of Townshend which, in a measure, reconciles us to the verdict. His insanity appears to have been *all talk*, and *no action*. Even his negroes he does not appear to have emancipated."¹⁶

The founders of the Association showed considerable and active interest in the psychiatric aspects of testamentary problems, and they crossed swords on occasion in court. In the famous case of Oliver Smith's will, Brigham testified that the late testator was sane, while Woodward testified that Oliver Smith was insane at the time he wrote his will. Isaac Ray and Luther Bell concurred with Woodward.

"Insanity considered in its civil relations" was a topic of great interest. The views of M. Sacase, Counsellor of the Court of Appeals at Amiens, were published in the French journal *Législation et Jurisprudence* in 1851, and the editor of the *Journal of Insanity* thought well enough of them to publish a detailed abstract for the benefit of American psychiatrists in the January issue of 1854.¹⁷

¹⁵ *Ibid*, X (1853-54), 181-182.

¹⁶ *Ibid*, p 183.

¹⁷ *Ibid.*, pp 276-280

The leading spirit who kept up this interest in "insanity in its civil relations" was, of course, Isaac Ray, the American pioneer and scholarly thinker in the field of medical jurisprudence of insanity.

Ray was hardly thirty years old when he had fully mastered the subject in all its aspects, historical, philosophical, clinical, legal, and humanitarian; he gave expression to his vast knowledge and humanitarian aspirations in his *Medical Jurisprudence of Insanity*, published in 1838, the first book of its kind in America.

The problem of testamentary capacity seems to have been one of Ray's favorite subjects. He testified in a number of law suits in which wills were contested, and he wrote on the subject. In 1863 he published an exhaustive report of "The Angell Will Case" covering more than forty pages.²⁸ In a sense we may consider these litigations involving a contest about a will as the first detailed socio-psychiatric case histories; perhaps it is this feature that attracted men like Ray and his colleagues. We find in "The Angell Will Case" the following

In the litigation of a will, a wider range of inquiry is opened, a larger variety of relations is exposed, than is permitted or required in that of a crime or a contract. The investigation may extend over a life-time, and be pushed into the inmost recesses of the inner life. In no class of cases is there more needed a familiar acquaintance with the operations of the mind, sound as well as unsound, in order to reconcile seeming discrepancies of testimony, an extensive observation, to show the full significance of many a trait, and the tact, springing from long experience and sagacity, that can enable one to appreciate the nicer affections of mental competence that result from cerebral disturbance.

Thus, what would first appear to be an interest dictated by more or less academic curiosity seems to have been a genuine conviction that "litigations of will" were a field of fruitful psychiatric investigation, a source for study of normal and abnormal psychology in its purely clinical, social, and cultural aspects. Some half century later psychiatry found in the general field of neuroses and schizophrenia what Ray and many of his colleagues sought and thought to have found in part in the study of testamentary problems.

As time went on this problem seems to have receded as one of the major points of psychiatric interest—at least in so far as it was reflected in the literature of the period. But psychiatry still paid considerable atten-

²⁸ *Ibid.*, XX (1863-64), 144-186.

tion to the problem as late as the beginning of the last quarter of the nineteenth century. This fact is reflected in the papers read before the Medico-Legal Society of New York, among which Isaac Ray's paper on testamentary capacity (1877) occupies an honorable place. In this paper Ray reviewed the chief varieties of mental disease, made a brief historical excursion in which he called attention to the legal tradition of relying on the superannuated psychopathology of Coke and Hale, reminded us that old age is not necessarily senility, and recalled the poet Waller's lines:

The soul's dark cottage, battered and decayed,
Lets in new light through chinks which time has made.

Ray called for greater respect for clinical psychiatry in place of the aged legalistic technicalities. He lamented "the disposition to form positive conclusions on the strength of a partial, one-sided observation," and concluded his paper by saying: "In presenting the subject of testamentary capacity in the way I have, it was for the purpose of giving to the pathological element the prominence it rightfully deserves, and which consequently ought to secure it a controlling influence in disputed cases. And let me say, in conclusion, that the administration of justice in this particular must often be imperfect, until the light of medical science is freely admitted and used,—not the light that has travelled down to us from the times of Coke and Hale, but that which we owe to the progress of knowledge during the present century—greater, far greater, indeed, than that of all centuries together."¹⁹

The exalted note with which Isaac Ray finished the reading of his paper is very significant. He was not alone, of course, in his enthusiasm and faith in psychiatry. All his colleagues shared and contributed to it, and all were preëminently concerned with everything that had a bearing on man's behavior at home, in his society, in his culture, and in his prison. But the paramount interest of the early psychiatrists was clinical; this clinical interest stood out despite the fact that they were very busy men whose time was absorbed with problems of hospital administration, hospital building, labor shortages, ventilation, dietetics, and heating. As I have said, it was this clinical interest that psychiatrists sought to satisfy in dealing with certain aspects of the civil law. Mental disease occupied a very inconspicuous place in civil law; or, to be more exact, questions

¹⁹ *Papers Read before the Medico-Legal Society of New York, 1875-1878* (New York, the Medico-Legal Society, 1886), pp. 422-440.

of mental disease were not yet considered by the civil codes as questions which only a specialist in mental diseases was qualified to answer. Consequently, the American psychiatrist of one hundred or of seventy-five years ago sought not only to further his clinical knowledge but to assert his clinical authority as a specialist wherever it was neglected, disregarded, or otherwise treated with disrespect. In attempting to achieve this goal, the early psychiatrist always tended to correlate his clinical studies with those opinions which the law had held for many generations. As we shall presently see, the psychiatrist himself had not attained that degree of scientific yet profoundly humanitarian objectivity which alone would hold out good promise for the attainment of his goal. In such problems as crime and punishment he found himself frequently too much a child of his age to stand before the court of law without bowing almost unquestioningly to some of the legal metaphysics. But in such matters as testamentary litigations the psychiatrist found it less difficult to be objective, detached, the pure clinician.

He was therefore able to call the attention of the specialist in medical jurisprudence to the fact that he, the psychiatrist, was—not more just, not more honest than the legal authority—but more learned in the subject of mental disease. A typical example:

When Dr John J. Reese, professor of medical jurisprudence and toxicology in the University of Pennsylvania, issued his *Text-Book of Medical Jurisprudence and Toxicology*, the *Journal of Insanity* observed among other things:

When on the subject of testamentary capacity, Dr Reese is emphatic in his opinion that a will made by a person suffering from typhoid fever should be held valid "provided he was not delirious at the time." Herein we must join issue with the author. In the last number of this *Journal*, Dr. Chapin, in an article on the "Mental Capacity in Certain States of Typhoid Fever," shows conclusively, to our mind, that even in the absence of delirium a typhoid patient may make a will of which he has no subsequent recollection, and in a manner, moreover, at total variance with his wishes on recovery.²⁰

The psychiatrist's serene coöperation with the law as it stood was unfortunately limited to the field of the rather neutral subject just reviewed. Very soon in his career as the medical officer on whose shoulders weighed the responsibility for the great class of the underprivileged called lunatics, or insane, the psychiatrist found himself in a position less peaceful. When

²⁰ *Am J Insanity*, XLI (1884-85), 353-354.

he was consulted on the mental state of someone who had made a contract or a will, he was able to express his opinion and to retire to his daily task of caring for the sick, without much concern as to the consequences to the contested contract or will in question. But when he was confronted with the problems involved in the curative control and management of his patients, or as Dr. Coventry put it "the propriety of confinement when danger to the individual himself or to others is apprehended," the psychiatrist at once found himself confronted with and involved in a number of conflicts.

There was the old tradition of treating the mentally ill, particularly the improvident, as criminals, which had to be combated and radically changed. There was the question as to who should be the final authority to decide whether an individual was sane or insane and, if insane, whether he was to be confined to an appropriate institution. This authority had to be decided upon and legally established, and the psychiatrist, the superintendent of the institution, was not always looked upon with favor or without suspicion by the law or by society. There was the great question of individual liberty, the constitutional rights of every citizen whether healthy or ill, sane or insane. The law—so charitable to the insane in many civil cases, and always so mindful of the good and safety of the community as a whole and of its individual members—was suspicious of the new specialty. It seemed to prefer, at least at first, to trust the layman—as represented by the overseer of the poor, the sheriff, the justice of the peace, or the twelve men comprising the jury—to pass upon the medico-psychological problems involved.

Matters were made more difficult for the psychiatrist by the fact that the public, for generations so neglectful and even contemptuous of the insane in the community, the public which has always been afraid of the mentally ill and has tolerated their imprisonment, their auctioning-off, and their suffering of many other indignities, the public too found itself suspicious of the very institutions which were created to house and to treat the mentally ill. The public seems to have discovered what the medical profession had tried to teach it for centuries, that the mentally ill are human beings who have rights and to whom the community and the medical profession have an obligation. This discovery led to a paradoxical suspicion of the asylums, which were considered places for incarceration, even as the ancient dungeons and later jails were.

All these contradictions, conflicts, currents, and countercurrents of

social emotions in relation to the mentally ill gave the head of the mental institution and his assistants deep concern; they stood always in the very midst of the stream of various conflicts theoretical and practical. At first there was no psychiatry outside institutional psychiatry, and therefore there were no psychiatrists outside the superintendents and their medical staffs. These from the very outset had to shoulder the burden of adjusting the relationship of custodial and curative psychiatry to the law. The need for such a relationship is peculiar only to this branch of medicine. The surgeon is never called upon by the law to comply with special procedures before he straps an anesthetized patient to the operating table, nor does the internist have to consult the legal authorities and obtain permission each time he would administer a strong hypnotic medicament or stimulant. The psychiatrist, however, because of the singular nature of mental disease, cannot even start restraining the free movements of the psychotic without due process. This is as it should be, but it also creates a special set of problems totally foreign to medicine and surgery.

This is why the problem of committing patients to institutions is so vital, and this is why the history of this problem is so intimately woven into the history of psychiatry. "The propriety of confinement" is a question which must be solved and decided upon before any intramural treatment can be instituted. The century that lies behind us has witnessed immense changes in the factual and procedural status of this problem. These changes were not always easy, and they were frequently accompanied by stormy conflicts, unreasonable attacks on the psychiatric profession, and political abuse on the part of some agencies of the government, which under unwise administrators and with the weight of formal authority impeded the progress of psychiatric administration in many parts of the country.

Linked with this problem of "propriety of confinement" were naturally a variety of issues of great civic and administrative importance, such as public or governmental supervisory control of the hospitals for the mentally ill, the propriety of restraint, the relationship of the medical to the civil authorities, and so forth. Many of the problems and issues involved have become more or less common knowledge, and it is unnecessary to reiterate these facts which were so clearly and so ably presented recently by Albert Deutsch in his *Mentally Ill in America*, and some twenty years before Deutsch in the exhaustive compilation, *The Institu-*



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tional Care of the Insane in the United States and Canada, which was painstakingly edited by Dr. Henry M. Hurd. The reader is counseled to peruse these two classics for particular details. Here only certain highlights of the developmental trends of the problems involved are to be briefly considered.

When our minds are turned toward pondering the development of the status of the mentally ill, we are wont to contemplate the past and to reassert that it was very bad. Bad it was, but if we are to consider any phenomenon of the remote past from the point of view of its humanitarian value as we understand this value today, we must also consider the whole cultural atmosphere and *niveau* of the section of the past under consideration, and thus establish a proper historical perspective. In the light of this perspective—we know that at the time the medical profession itself was neither properly organized, nor adequately aware of its task regarding the mentally ill—it is understandable that the community could perceive in the insane only a disturbing element, a phenomenon injurious to the peace of mind of the average citizen and to the orderly quiet and security of the community. No wonder then that the law passed by the Commonwealth of Massachusetts in 1797 dealing with the apprehension and disposal of the insane was entitled, “An act for suppressing Rogues, Vagabonds, Common Beggars, and other idle and lewd Persons.”

The short half century that lay between the enactment of this law and the founding of the Association of Medical Superintendents was marked by considerable intellectual, cultural, and scientific advance. A number of hospitals for the mentally ill were founded, particularly in the thirties and early forties of the nineteenth century, and the insane were unevenly strewn in hospitals, almshouses, and penal institutions throughout the country.²¹ There was no uniformity of principle in this distribution, and less justice. For decades, the cumulative emotions of the public against the abuses with which the insane had been treated for generations turned against the hospitals themselves, and as late as the early 1880s the hospitals were still the butt of suspicion and abuse. The public as well as the courts was well aware of the confusion, and the circumstances themselves pushed events toward a solution.

The *Philadelphia Medical Times* of July first, 1882, expressed in vivid language the mood of certain sections of the public and all their mis-

²¹ See Dr. Hamilton's and Professor Shryock's chapters in this volume

guided efforts. The *Times* called the nineteenth century the "Age of Societies," because

The rage for union is triumphant; from red-handed communism to Bible-distribution, every possible wish, thought, or hope of the human race seems to have its association. Therefore we are not surprised at the 'Proceedings of the National Association for the Protection of the Insane,' which has recently been put upon our book-table. Reporters, disguised, forcing their way into insane hospitals in order to make a sensation and earn their penny a line, lawyers overbrimming in court with philanthropic eloquence concerning the sufferings of some client not too insane or too impecunious to recognize the golden springs that move legal emotion to its centre, learned judges on their benches, newspaper editors in search of a sensation, and doctors eager for notoriety and fees, have made such a din that a quiet voice asking for protection of the sane is not to be heard; and as there is no taint of consulting visits or legal processes upon the breezes that blow from such quarters, we suppose it will not be possible to have a flourishing society to protect the sane against the insane; but assuredly the sane suffer more from the insane than do the insane from the sane.

Sitting in court the other day we saw an old man with face scarred and furrowed as a tree torn and blasted with lightning: one eye gone, health ruined, a victim of the insane,—of the vitriol-man. Picking up the newspaper this morning, the first paragraph gave account of the murder of a family by their crazed mother. Going into a patient's house, the story was told us of the whole family life ruined by the doings of a member really insane, but not yet quite insane enough for the law to step in—of a daily martyrdom by worry beyond endurance . . . The truth is that physicians in charge of insane asylums, and physicians who give certificates, almost without exception are both able and honest men; and it is little less than an outrage that any physician should try to climb into power or wealth over the shoulders of these men by the cruel hooks of public prejudice.²²

The state of affairs gleaned through the above editorial prevailed almost forty years after the founding of the Association of Medical Superintendents. Deplorable as this was, it was significant in that it demonstrated a vital public interest in the problems of the treatment of the mentally ill. That the Association contributed to the awakening of this interest cannot now be contested; when it was founded there was little public concern about the problem.

Three months after the Original Thirteen foregathered to discuss their problems, a case was tried in the Supreme Judicial Court of Massa-

²² Quoted by *Am. J. Insanity*, XXXIX (1882-83), 85-86

chusetts which was to go down in the history of American psychiatry as a turning point in the legal relations of the insane. In January, 1845, the court sat for two days to consider the case of Josiah Oakes, who was a patient at McLean Hospital upon the application of his sons. Oakes petitioned for his discharge. Justice C. J. Shaw, who presided over the proceedings, proved in this case—as he continually did in criminal cases in which the plea of insanity was interposed—an enlightened liberal. He considered it a matter of humanity to confine a mentally sick person in a hospital, such confinement to be considered an adjuvant of treatment and not a violation of one's constitutional rights. The report of this case of habeas corpus as published in the January, 1846, issue of the *American Journal of Insanity* bears the following heading:

A person who is insane, or delirious, may be confined, or restrained of his liberty, by his family, or by others, to such extent, and for such length of time, as may be necessary to prevent injury or danger to himself and others

Such confinement and restraint may be in his own house, or in a suitable asylum, or hospital.

The repetition and frequent occurrences of acts, without any motive sufficient to actuate persons of ordinary sense, are evidence of aberration of mind, and in such cases, accumulation of proof becomes important.

Such aberration of mind will authorize the restraint of the person subject thereto, although he has not committed any actual violence.²³

The chief proponent and the most scholarly blazer of new trails in this field of jurisprudence in American psychiatry was, again, Isaac Ray. The Association was not four years old when Ray was able to report the advance made by the state of Maine regarding the legal relations of the insane. With his characteristic terseness and sober acidity, Ray remarked, "It is not one of those subjects that strongly appeal to the attention of legislative bodies by their intimate connection with some scheme of temporal advancement. It presents to the Solons of the time, no other claims than those of suffering humanity, and hence is too often allowed to go its way until a more convenient season."

Two years later, in 1850, Isaac Ray produced a project of a law covering all the legal relations of the insane, civil and criminal. This document is in many respects more advanced than some of our laws of today, almost one hundred years later. In it he states: "It will be regarded hereafter as a curious fact, that while the most of our insane hospitals have

²³ *Am. J. Insanity*, II (1845-46), 225

²⁴ *Ibid.*, IV (1847-48), 211.

been created and more or less maintained by the State, the confinement of the insane is regulated in most, if not all the States, by no statute law whatever."²⁶

And again: "This condition of the law is fruitful of evil to all parties concerned," and the legal decisions are "not in accordance with dictates of humanity, or of medical science." Ray speaks of "seclusion for the purpose of cure or custody." He recalls Justice Shaw's decision in the Oakes case and his reference to "the great law of humanity," expressing himself in favor of a legislative act which would authorize the relatives of a patient to commit him to a mental institution. Speaking of the many wrongs the insane are capable of committing, Ray pleads that the insane be protected by law against committing these wrongs, and he adds in his characteristic manner: "It may be objected, perhaps, to this view of the matter, that such acts should be regarded as a visitation of Providence, or to use the legal phrase, the act of God, the consequences of which, like those of storm or fire, should be borne exclusively by the aggrieved party. They often certainly seem to have this character, and it would be little better than heathenism to treat them as the acts of a rational being."²⁷

Isaac Ray had in mind a number of cases civil and criminal which he had studied and in which he had been called upon to testify. He knew the law books, but he knew the court room too, and he knew the hospital ward and its occupant. The Association of Medical Superintendents followed his lead in matters of medical jurisprudence of insanity, but changes were brought about very slowly.

The Association was twenty years old when it appointed a Committee on Lunacy Laws to study the status of these laws in all states. Isaac Ray was chairman of this Committee.²⁸ The problem has grown in scope and complexity. Some states very early established proper administrative apparatus to deal with the problem; others were too slow to recognize the need. The state of Vermont has had a Commissioner of the Insane since 1845, while in other states such an office was not created until a quarter

²⁶ *Ibid.*, VII (1850-51), 217.

²⁷ *Ibid.*, p. 230

²⁸ In the January, 1864, issue of the *Journal of Insanity* a letter from Ray was published which read in part. "The Chairman of the Committee appointed at the last session of the Association of Superintendents, on the laws relating to insanity, in the various States of the Union, regrets that he has received reports from only a few of the members of the committee, and that some of those are entirely silent on some of the prescribed points. Unless the members report at an early date it will be impossible for the chairman to perform his part of the work in season for the next meeting." (XX, 355-356.)

of a century later; New York appointed a Commissioner of Lunacy in 1873.

As early as 1851 the state of Rhode Island had a definite, well-established procedure. Its General Assembly enacted a law requiring certification by one physician before a patient could be admitted to Butler Hospital. In the words of the law, "any respectable person" could apply in writing stating that a certain person was insane, thereupon, a judge of the Supreme Court would consider issuing an appropriate order.

The editors of the *Journal of Insanity* commented favorably upon the Rhode Island "Act in relation to the Butler Hospital for the Insane." They expressed their satisfaction with the fact that this law followed in the main Isaac Ray's project submitted to the Association in Boston only one year before. However, they observed that "the efficiency of the present act has been somewhat impaired by omitting some important provisions in the proposed law [Isaac Ray's], viz. the sixth, seventh, ninth and tenth sections. This certainly is acting the play with the part of Hamlet left out."²⁸

For fifty years after the founding of the Association the problem of adjusting the legal requirements to the curative and custodial needs of the mentally ill was discussed, worked over, passionately elaborated or simplified by the psychiatrists, lawyers, charitable societies, state governments, and some of the insane who—utilizing the privilege of the writ of habeas corpus—were able to air their realistic or fantasied grievances before the courts of law. The case of Mrs. E. P. W. Packard is in this respect to be particularly noted,²⁹ for almost seven years this case remained before the public eye. Despite the fact that the administrative apparatus for supervision and control of mental institutions was being improved and refined, the general attitude of suspicion and distrust seemed to be spreading.

The state boards of charities (the first of these was organized in Massachusetts in 1863), lunacy commissions, societies for the protection of the insane, medico-legal efforts in and outside the psychiatric profession, all were preoccupied with the status of the insane in a spirit of fervor and idealistic aspiration which all too frequently led to recriminations and bitter ardor. The noble principle promulgated by Horace Mann that "the insane are the wards of the state" seems to have brought with it, in

²⁸ *Ibid.*, VIII (1851-52), 150.

²⁹ Cf. Albert Deutsch, *The Mentally Ill in America* (New York, Doubleday, Doran, 1937), p. 423.

the very process of its practical realization, a welter of ill-feeling and confusing rancor. Nathan Allen, the Lunacy Commissioner of Massachusetts, summed up the situation rather poignantly when he said in his report of 1874, "There has grown up and existed for some time an antagonism of feeling and interest between hospitals, the superintendents and trustees as a body, and the general public . . ." and, quoting one of the trustees, "It seems as if the public believed that every man connected in any way with a hospital for the insane had entered into a conspiracy to deprive the patients of all their rights and to do violence to all the relations of life."⁸⁰

Political interference added to the difficulties. A typical although rather extreme example is seen in what the *Lynchburg Virginian* of May 14, 1881, called "a law passed by our Communistic Legislature which turned out the Board of Directors" of the mental institutions and replaced them with "men of whose existence until so appointed, the world was ignorant. . . . Two of these boards held meetings and turned out every officer of the Institutions at Staunton and Richmond."

The habeas corpus proceedings which the editors of the *Journal* reported in 1883 were wasteful of time and energy and resulted in setting free definitely sick individuals. In the writ the patients were called "the prisoners." In one of his decisions Judge Shipman of the state of New York stated with admirable insight, "As a rule, courts cannot write a record that will bind an insane person at all. It is only when a man is sane that it can enter a judgment that he is insane, which will establish the fact against him conclusively."⁸¹ But such enlightenment was at the time comparatively infrequent. The state of New York was in the lead as far as working for the solution of the problem was concerned. In 1888 Stephen Smith, once Commissioner of Lunacy, appeared before the National Conference of Charities held at Buffalo on July 5 and submitted "the project of a law, for the commitment of the insane to custody, to be adopted by several states." In this connection, it is interesting to note that the psychiatrist favored a legal enactment of a statutory nature as regards "furloughs" or "leaves of absence on trial," which are known today as "parole."

Toward the close of the eighties the general legal principles and procedural details became more or less crystallized. Despite a number of

⁸⁰ *Ibid*, p. 426.

⁸¹ *Am J Insanity*, XXXIX (1882-83), 309.

variations as to details in many states, the problem of safeguarding the rights of patients and of protecting the members of the profession sufficiently so that they might be able to discharge their medical duty without too much outside interference and in moderate peace was more or less uniformly solved.

It really matters little that the certificate of two physicians and a court order are required in New York to commit a patient, and that a jury verdict is required in Illinois. Considerable and progressive improvement, of course, is marked in the establishment of the Department of Mental Hygiene in New York (1927), as compared with the one-man commission in lunacy (1873), the three-man commission (1889), or the state hospital commission (1912). There is also an improvement in the procedure of commitment by jury in Illinois, a procedure (established in 1869) which was repealed in its old form in 1893 but is still preserved for some cases.

All these improvements make for greater efficacy of administrative functioning, but the real improvement should be measured by the full recognition of the medical authority of the psychiatrist. In this respect the law still, one hundred years after the profession was officially established, leaves a great deal to be desired. The "examiner in lunacy" and the "qualified psychiatrist" are still insufficiently defined concepts. This lack of legal clarity is but the reflection of the general prejudice which still lingers on with regard to psychiatry and the psychiatrist. Apparently it is this prejudice that is responsible for the very slowness with which we have evolved and with which the achievements in this field have materialized. It took years for the minds of men to become sufficiently clear on the subject so that Isaac Ray was able to give a concrete formulation of a project of a law, and many more years were required before psychiatrists were able to debate specific issues and speak not of creating new but of improving the existing laws which in the meantime had been established. It has always been and still is a struggle between the progress of medical psychology with its inherent humanitarian spirit and public opinion. The public is always far behind the times in such matters, sandwiched in between the two cultural forces of the law and psychiatry, standing firm on the pedestal of its past, leaving it unwillingly or at any rate cautiously, never with diffidence but always with the certainty of being right in the abstract and in form. To use the words of Dr. John H. Callender, president of the Association of Medical Super-

intendents in 1883, it was always "a matter whose intrinsic legal difficulties have vexed the jurisprudence of every country."

In his presidential address Dr. Callender analyzed Ray's project of a law propounded nearly a quarter of a century before and called attention to the fact that the psychiatric profession had no quarrel with the law; it only wished to make its reasonable contribution to the vital problem of proper and unimpeded treatment of the mentally ill. Speaking of the laws projected by the Association, Callender said, "Some of their features have found favor in quite a number of the States, but the sensitive fondness for antiquated precedents, of the profession which boasts its science as 'the perfection of human reason,' and whose members usually compose two-thirds of all the legislative bodies in the country, and whose work frequently produces a mystification in laws to which the confusion of Babel would have been concord, and Cimmerian darkness as mid-day splendor, have thus far prevented their general acceptance."²²

With the century moving to its close, it was clear that as public opinion became crystallized in the course of the years, the psychiatric profession became more certain of its position and more definite as to practical details. When Dr. Stephen Smith presented his project of a law and made his report on the care and commitment of the insane, Dr. Walter Channing of Massachusetts wrote a long letter to the *Journal* subjecting the report to judicious scrutiny. "Why," asks Channing, "Why endeavor to specify in a law the manifestations of disease which will entitle the insane man to hospital treatment? Such a clause in a law as Section I only befogs the lay mind, and as far as having any influence on medical opinion, which sends the insane man to the hospital, is a dead letter." And further: "Neither justices of the peace, nor superintendents of the poor, are fitted to be clothed with the powers here given, and furthermore such complicated proceedings are entirely unnecessary."²³

Channing appeared a little uncertain as to the great value of voluntary admissions, which it may be noted had existed in his state since 1881. "The voluntary law then in Massachusetts is honored only in the breach, being constantly broken"—a mental attitude not to be shared by the generation of psychiatrists which followed Dr. Channing. Dr. Channing saw in the newly suggested law for New York the definite influence of the law of Massachusetts. The New York psychiatrists saw in certain

²² *Am. J. Insanity*, XL (1883-84), 22-23.

²³ *Ibid.*, XLVI (1889-90), 298-299.

changes suggested in Illinois the influence of the New York law. It was evident that a uniform trend was spreading over the country.

Two years before commitment by jury trial with the patient present in court was repealed in Illinois, Dr. Sanger Brown published a paper on the proposed changes of the Illinois insanity laws. This paper was read before a joint meeting of the Chicago Medical Society and the Medico-Legal Society of Chicago in February, 1891. Pliny Earle took part in the discussion. The *Journal of Insanity*, reporting briefly on that meeting, minced no words as to the cruelty of commitment by jury. "Dr. Sanger Brown's proposals are all sensible and reasonable; though some of them show a greater deference to the popular unreasoning prejudices than would be considered necessary in this meridian. However, they are in their principal features remodeled after the law of New York."⁸⁴ (We must not lose sight of the fact that this took place in 1891, only three years before the Association reached its half century mark.) "Dr. Archibald Church's remarks in the course of this discussion will serve to show," the *Journal* continued, "that our comments have not been guilty of extravagant language"—that it was the old and ugly principle and procedure of *de lunatico inquirendo* which brought the patient into the court room.

Dr. Church's remarks were as follows:

I have seen a man suffering, unfortunately for him, from acute mania, shackled hand and foot and then placed in a great canvas sack which was tied around his neck, and in that condition, carried thirty miles to the county seat, and subsequently, on the same day, brought fifty miles to the asylum, without any opportunity to attend to the calls of nature. I have found that man one mass of bruises from the top of his head to the soles of his feet, and I have seen him succumb in six days, and I attribute it to this treatment. When you have seen such things under this law it needs no argument to show that it is not the law for this time and this community. When you have seen a woman who scarcely stood five feet high, bound and tied with forty feet of rope that had been used to tether a cow, and in that condition, held down by four men, carried in an open wagon twenty miles to be tried, and still in that condition brought to the asylum, you will realize that this law is not a beautiful thing. When you have seen a man taken from within a stone's throw of a State institution, shackled hand and foot and carried twenty miles to the county seat, struggling with all his might the entire distance, and immediately brought back the same distance in the same plight, in a closed carriage, out of which he had managed to knock all the glass, his legs sticking out of one

⁸⁴ *Ibid.*, XLVII (1890-91), 586.

window and his head out of the other, cut and maimed, bruised and bleeding, with scarcely any clothing left upon him, and have seen him die within twenty-four hours, you will understand that this law is not the humanitarian triumph it is claimed to be.⁸⁵

In 1894, when the Association was just fifty years old, Dr. G. Alder Blumer reminded us in his paper, "The Commitment, Detention, Care and Treatment of the Insane in America," that the words of Pliny Earle (uttered a quarter of a century before) were still valid and potent: "The most that can be done is to affirm and reiterate some general principle that commends itself to intelligent approbation and to leave it to make its way among men of sense and influence, as all good general principles will, until it becomes the common sense of the community."⁸⁶

Dr. Blumer called attention to the fact that in Mississippi, Texas, Wyoming, and some other states a public patient is committed on the verdict of a "jury of laymen, no medical examination being required. This, to say the least, is a semi-barbarous method and involves the cruelty of making sick persons objects of curiosity and ridicule among public spectators. In Illinois, Kansas and Minnesota, commitment is on the verdict of a mixed jury of laymen and physicians. The law requires that at least one physician shall be on the jury. This is only a shade less barbarous."⁸⁷

Dr. Blumer felt constrained to "affirm and reiterate" that "No superintendent could have any motive to connive at an improper commitment, and even assuming the possibility of a corrupt official at the head of an institution, any conspiracy would have to involve many others both inside and outside of the institution."⁸⁸ Blumer recalled the words of Lord Shaftesbury (permanent chairman of the British Lunacy Commission for thirty-two years), who said before the special commission of Parliament on lunacy laws in 1877: "I am ready enough to believe that when temptation gets hold of a man's heart he is capable of doing anything. But, I am happy to say, Providence throws so many difficulties in the way of these conspiracies that I believe conspiracies in ninety-nine cases out of a hundred to be altogether impossible."⁸⁹

And finally, as if to emphasize that the issues involved were purely

⁸⁵ *Ibid.*, p. 587.

⁸⁶ *Ibid.*, L (1893-94), 540.

⁸⁷ *Ibid.*, p. 541.

⁸⁸ *Ibid.*, p. 540.

⁸⁹ *Ibid.*

medical and humanitarian and not formal, Dr. Blumer recalled a passage in Dr. Godding's address to the Conference of Charities a few years before: "There is to be less laying of corner-stones with appropriate ceremonies, but more ordinary brick-work; building to anticipate rather than follow the needs of the insane, and so, with no flourish of trumpets, but silently keeping step in the march of human brotherhood round the world."⁴⁰

This practical, humanitarian motive expresses both the summary of the first fifty years of the Association's existence as well as a motto for the fifty years to follow. We shall not devote so much space to or supply so many details about the second fifty years, the close of which this volume marks. This—not because these fifty years do not deserve the same attention or because they offer less food for reflection on the subject which occupies us here—but because historically the second half of the Association's century is still too close to our own time, and in addition it is characterized more by the utilization and development of what the first fifty years had achieved than by any original contributions in this field.

The term "lunacy" has fallen into complete disrepute, if not yet total oblivion. The same much hoped for fate has befallen the term "insanity." Both are still used by lawyers, in court rooms and in legal documents. Neither is used by the scientific psychiatrist, unless for the purpose of some qualifying emphasis of implied or overt irony. The first fifty years performed the immense job of psychiatric maturation. Ideas, trends, humanitarian principles in the psychiatric management and care of the mentally ill—all were developed and most were conceived during those first fifty years, and were bequeathed by way of the implacable continuity of history to the half century to come. It is a matter of rather gross historical irony that Weir Mitchell, a psychiatric outsider, should have taken psychiatry to task for its intellectual and scientific isolation at the very celebration of the Association's semi-centennial. Weir Mitchell, a self-willed and alert contemporary, could not but fail to grasp the historical perspective as it concerned psychiatry fifty years ago, and he failed to notice that while he came consciously to condemn he actually voiced many of the aspirations of psychiatry itself, aspirations which could not have been materialized or even properly crystallized before. They could not have matured earlier because the business of the legal relations of the insane was neither a matter of theoretical principle nor of abstract

⁴⁰ *Ibid.*, p. 547.

moral values; it was the most serious, most pressing job to be done, and until a satisfactory form of its solution was in sight the full attention of the psychiatrist could not be focused on other problems.

The general confusion in regard to the problem had to be resolved, and the legal status of the mental patient had to be made humane and orderly. This required an immense amount of preparatory work, and the work was brilliantly done not only by such gifted and inspired men as Isaac Ray but by the Association as a whole. The second fifty years had but to follow in the footsteps of the first fifty to be progressive and creative in the matter of humanized reform in the legal position of the mentally ill. Without that reform, proper treatment was frequently jeopardized or made totally impossible. Since 1894 psychiatry has continued to combat the injustices which the leaders of the first half of the century were unable fully to eradicate, while at the same time it continued to develop what the preceding generations of psychiatrists had succeeded only in outlining, "affirming and reiterating."

As late as 1933, almost forty years after Blumer's eloquent summary of the situation and his appeal for betterment, there were still fourteen states in which mental patients awaiting commitment were legally detained in jails, and six states permitted such detention if the patient was violent.⁴¹ In the same year a bill introducing more progressive commitment laws in California, and incidentally removing from the sheriffs their function of handling patients to bring them to a hospital, was vetoed by the governor, because he was petitioned to do so by the California Sheriffs' Association.⁴² Very often in the past and not infrequently even today, to use the expression of a former president of the State Board of Charities of New York, "Legislative embarrassment was resolved into an administrative difficulty," or vice versa.⁴³

On the other hand, a definite change has taken place in what is still known as the legal relations of the insane. An old trend has developed into a more definite psychiatric orientation. The idea of voluntary commitment, or, to be more correct, voluntary entrance in a formal legal manner into a mental hospital, was first given legal recognition by Massachusetts in 1881. But it was the twentieth century which established this procedure as a definite and frequent practice. In the meantime legal

⁴¹ Deutsch, *op cit*, p. 434, citing Glenn Myers

⁴² *Ibid.*, p. 439.

⁴³ Oscar Craig, "The New York Law for the State Care of the Insane," *Am. J. Insanity*, XLVIII (1891-92), 172-183.

involuntary commitment became more or less uniform; for details the reader is referred to the crisp and more than adequate summary by Deutsch, which need not be recapitulated here.⁴⁴

As to the development of voluntary commitment⁴⁵ before 1887, only three states had voluntary admission laws: Massachusetts (since 1881), Maryland (since 1886), and Virginia (since 1887). By 1924 twenty-eight states had such laws.⁴⁶ Overholser summarized the situation as follows:

The voluntary admission law is a useful provision from a psychiatric and social point of view, encouraging early treatment and thereby hastening recovery in many cases.

To be most useful it should be open to all suitable applicants, whether or not they are able to pay for their maintenance.

Patients with practically any form of psychosis in the early stages are admissible, as are also psychoneurotics.

Alcoholics and drug addicts cannot be satisfactorily treated on a voluntary basis.

A voluntary application is a form of contract which is valid if the patient is competent and is acting of his free will.

Only persons who are competent should be allowed to enter as voluntary patients, and committed if they later become incompetent.

The length of required notice should be only sufficient to allow time to notify the patient's relatives that he is about to leave or to have him committed in case release is not advisable.

The voluntary admission law was first called into question before the Supreme Court of Massachusetts in 1922, and this court rendered a decision which is valuable as indicating the proper procedure in certain cases.⁴⁷

It is of utmost interest to note that eighty years after the Association was founded, while the center of attention had shifted somewhat, the tone and the spirit of the discussion were reminiscent of many a discussion of years ago. Thus Arthur Ruggles, in discussing Overholser's paper, pointed out some of the inconsistencies of legal interpretations and concluded by saying: "If these things could be carried out in a uniform way throughout the country, it would be a splendid achievement. This would be one of the greatest forward steps for the medical oversight of the whole problem of mental disease."

⁴⁴ Deutsch, *op cit*, pp. 427-437

⁴⁵ I follow here Dr Winfred Overholser's excellent outline, in "The Voluntary Admission Law," *Am J Insanity*, LXXX (1923-24), 475-487. Discussion of above by Dr. Arthur H Ruggles and others, pp 487-490

⁴⁶ *Ibid.*, p 476, fn. 6.

⁴⁷ *Ibid.*, p 487.

The old question of the violation of the Fourth and Fourteenth Amendments to the Constitution of the United States, if a mental patient is "improperly" admitted or "forced" into a mental hospital, still stands unsolved at the close of the first century of the Association. Samuel W. Hamilton, in his discussion of Overholser's paper on the Voluntary Admission Law, expressed his highly acceptable opinion quite trenchantly when he said:

If a man has an accident in the street and goes to a hospital and the radiogram shows that he has a fracture at the base of the brain, he will be kept there until some sort of provision is made for his suitable care and it won't make any difference whether he protests or not, but if the X-ray does not show he has a fracture of the skull, various legal restrictions stand in the way of proper care. What can be done? I think the sooner that distinction is swept away, the better for the patients. The time is coming when some of those old safeguards, erected by legal authority and legal decision so that scheming relatives could not act in collusion with the superintendent of the state hospital and hold some sane person behind the bars, can be swept aside. In this connection think of the alcoholic. Though deprived of liberty in a hospital, still there is no question raised as to whether the man with alcoholic delirium should be sent to the hospital; once in the hospital he stays there until his delirium is over.⁴⁸

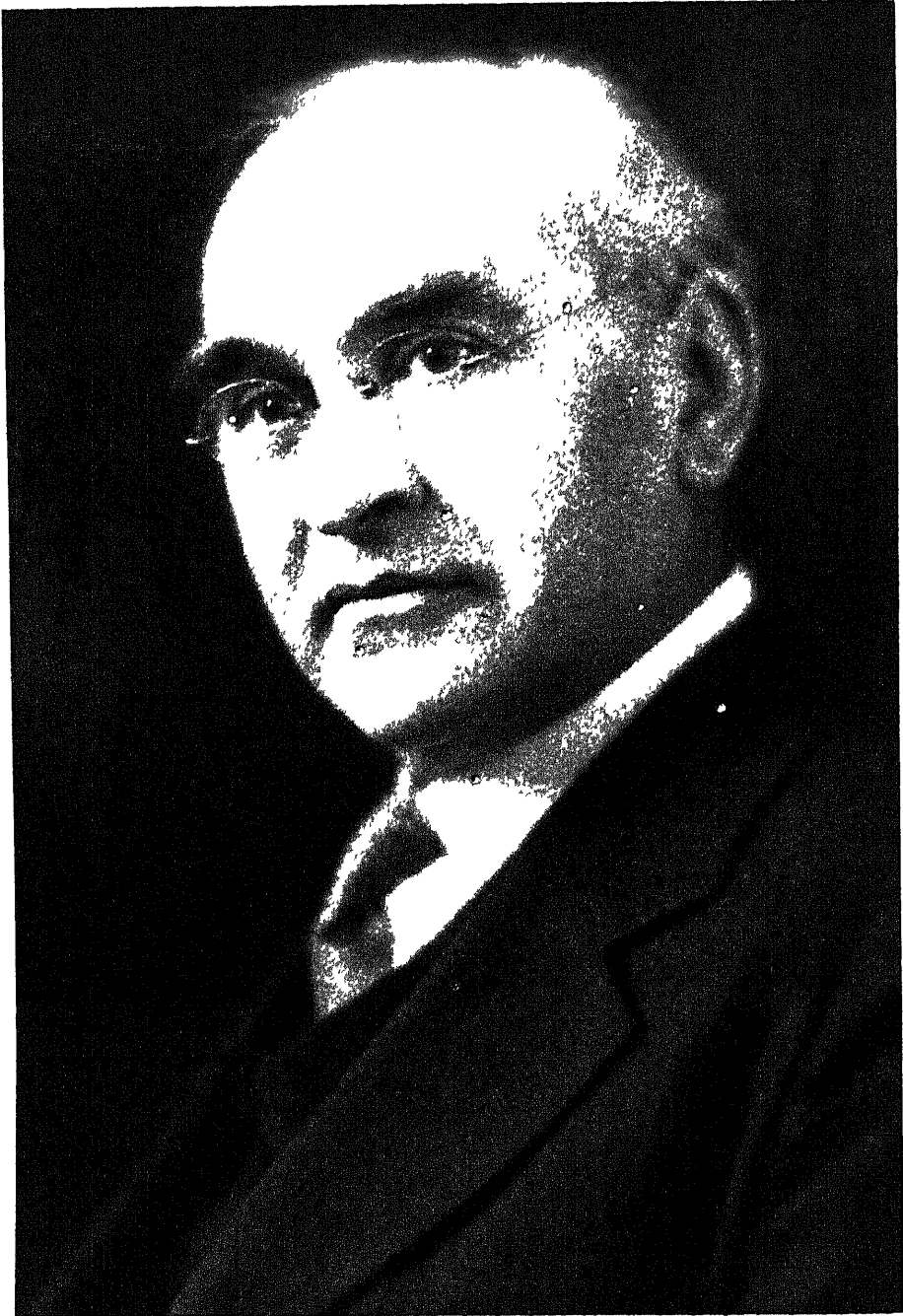
In the course of the same discussion Dr. Hobbs cited two very telling experiences with courts in Ontario, one in which the Chief Justice of Ontario presided. In both cases the court ruled in favor of the mental hospital. The lawyer naturally dissented. As Dr. Hobbs relates the story in part:

My lawyer constantly argued with me that I was wrong. He says you may admit a patient in the early stages of mental trouble as a voluntary patient, but if the patient develops into an acute mental case, you should have the patient committed. . . . He and I argued the question for 21 years, but in both cases in which the institution was sued both judges ruled in favor of the institution. The revision judges allowed the clause to stand in the statutes recognizing it to be a good law so that patients may admit themselves saving them a certain amount of publicity. . . . This voluntary clause applies to private institutions in Ontario for the care of borderland or mental patients which are constantly inspected by boards appointed by the government, the chairman of which must be the county judge.⁴⁹

It is clear that if the theory of the law affecting mental patients still shows decisive strains of superannuated formalism and ancient preju-

⁴⁸ *Ibid.*, pp. 488-489.

⁴⁹ *Ibid.*, p. 489.



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dices, the practice of the courts and many new laws have been well-nigh revolutionized since the days when the overseers of the poor and the local jailers had oversight over the greatest majority of the mentally ill.

The law, whether protecting the community from a dangerous psychotic or defending the psychotic's constitutional rights which he was unable to exercise or enjoy, had and strictly speaking still has no concern as to the treatment and ultimate cure of the very patient whose rights it wishes vigorously to protect. The Association (and ultimately psychiatry as a whole), having primarily a therapeutic concern, was naturally eager to convert the law to its point of view. Were the lawyer successful in converting the psychiatrist to his purely legal outlook, the therapeutic intent would naturally suffer. From this standpoint it is impossible to overestimate the educational importance of psychiatry during the past century, and it is easier to understand why the Committee on Legal Measures and Laws of the First International Congress of Mental Hygiene, held in Washington, D. C., in 1930, recommended that "Admission to a mental hospital for treatment should be made as informal and easy as the constitution and the laws of the country would permit."

The above general discussion of psychological and sociological conflicts underlying the law in its relation to mental illness will easily suggest that the problem, intricate though it appears, is that of educating the legal mind and changing the laws rather than changing the psychiatric attitude as that of a medical discipline. The history of the problem and its vicissitudes, even though presented here only in sketchy outline, clearly shows that psychiatry cannot change its fundamental attitude and remain a medical, therapeutic discipline; it may, does, has, and will acquire new and greater knowledge, but it does not change. The law, on the other hand, is the agency which must adjust itself to the newer knowledge. It is obvious, of course, that the law is not an autonomous agency in human society; it is an integral part of the sum total of cultural patterns which we are wont to call a given civilization. Therefore, the law depends on the changes which constantly occur in our culture, its psychological orientation, its sociological ideology, and its humanitarian growth on that which Chief Justice Shaw of Massachusetts called "the law of humanity" in the *Josiah Oakes* case one hundred years ago.

The simple enumeration of these changes, which are not only hoped for but imperative, would at once suggest the immensity of the educational task which psychiatry—as one of the most potent expressions of

modern culture—had and still has to perform. The difficulty of this task and the efficacy with which it has been performed are well illustrated, we believe, by the review and discussion of the “legal relations of the insane” in their civil aspects. One can say that on the whole the psychiatrist successfully rebelled against more frequently than he reluctantly served that which had outlived its usefulness on the statute books or on the trodden path of the common law, some ruts of which kept “the common sense of the community” on a rather low or primitive level.

If the civil “legal relations of the insane” were the only legal relations in which psychiatry is involved, we could say without hesitation that the psychiatrist was fully successful in his battle with the law. The law gave in without having to be vanquished; psychiatry won without enslaving the defeated opponent and has preserved all due respect for this opponent, with whom it continues to live in a spirit of coöperative effort. The old conflict and animosity have become transformed into intellectual disagreement, dispassionate, rational argumentation, and the coöperative pursuit of a common goal—the protection and welfare of the individual in society and in his personal life.

There is, however, one aspect of the legal relations of the insane which is still dominated by all the conflicts of past centuries and still pervaded by the spirit of distrust. This is the aspect touching the problems of crime and mental disease. In this field, the psychiatrist himself has been far from enjoying freedom from inner cultural conflicts, and his attitude toward the law has been therefore neither constant nor always medical—that is, curative. In this field, both psychiatry and the law seem to have been under the pressure of necessity for a cultural change; the history of this relationship is intense and dramatic. It represents an as yet unfinished page of history, and yet one already replete with significant and highly expressive lines.

Six years before the Association of Superintendents was founded, Isaac Ray made his first contribution to the problem. He was then just over thirty years old, yet he was already a scholarly expert and judicious thinker in the field of “Medical Jurisprudence of Insanity.” Ray’s book, bearing the above title, appeared in 1838, three years before he became superintendent of a mental hospital, five years before the formulation of the famous McNaghten case. It has the distinction of being the first American publication on the subject—it is well to note that the first contribution in this field was made by a physician. For over forty years it

enjoyed the position of being the most authoritative book on the problem, and it went through more than half a dozen editions. During the forty-three years which elapsed between the appearance of the book and the death of Isaac Ray, he dominated the medico-legal thought of American psychiatry, even though many in the Association disagreed with him, and at times violently. Ray was not only ahead of some of his colleagues but ahead of his time in the problems touching upon the medical jurisprudence of insanity. His book therefore deserves special attention, although it appeared before the Association was organized. It was a true forerunner and milepost on a highway of progress which was seldom peaceful and frequently stormy.

Ray approached the subject of medical jurisprudence of insanity not only as a psychiatric thinker but as a scholarly, thoughtful historian. His preface and the chapter entitled "Preliminary Views," comprising a total of seventy-three pages (out of a total of 481 of text), represent the first comprehensive historical review of the subject written by an American, and one of the very best in the whole history of the subject. To Horace Mann, "to whose persevering exertions, our country is mainly indebted for one of its noblest institutions for ameliorating the conditions of the insane," the book was "respectfully inscribed as a humble acknowledgment of esteem."

The spirit of the work, the general attitude of the psychiatrist toward the prevailing legal traditions in relation to the mentally ill, seem not only familiar to the present-day psychiatrist but even at times contemporary—all this despite the fact that the book was written by a young general medical man over one hundred years ago.

The opening sentence of the preface sounds like the habitual refrain of the present-day student of the medical jurisprudence of insanity: "Few, probably, whose attention has not been particularly directed to the subject, are aware how far the condition of the law relative to insanity is behind the present state of our knowledge concerning that disease."

Ray acknowledges the progress made "to promote the comfort of the insane, and so much improvement has been effected in the methods of treating their disorder, as to have deprived it of half its terrors." Yet, "it is both a curious and a melancholy fact, that so little has been accomplished towards regulating their personal and social rights, by more correct and enlightened principles of jurisprudence."

Ray reflects the awareness of the psychiatrist that his clinical orienta-

tion is not very welcome to the professional legal mind, and he says, "Before being condemned for substituting visionary and speculative fancies, in the place of those maxims and practices which have come down to us on the authority of our ancestors, and been sanctioned by the approval of all succeeding times, he [the author] hopes that the ground on which those alleged fancies have been built, will be carefully, candidly, and dispassionately examined."⁸⁰

"That much of the jurisprudence of insanity, in times past, should bear marks of the crude and imperfect notions, that have been entertained by its pathological character, is not to be wondered at; but, it is a matter of surprise, that it should be adhered to, as if consecrated by age, long after it has ceased to be supported by the results of more extensive and better conducted inquiries."⁸¹

After a survey of the older views, Ray leads us through the maxims and opinions of Hale, Coke, Hardwick, Eldon, and the incongruities resulting therefrom and from the legal definitions of lunacy, idiocy, and "unsoundness of mind." He remarks, "That it should still continue in a country [England], where it is linked in with a system, whose foundations are in the very constitution of the government, is perhaps not strange; but, that it should be used in some of our own states, which are untrammelled by such considerations, is certainly an anomaly in legislation."⁸²

When Ray enters upon a consideration of the criminal as contrasted with the civil law, he is not less earnest but noticeably more dissatisfied. Speaking of the application of the law to criminal cases:

There is much of the same respect for antiquated maxims, that have little else to recommend them but their antiquity, and are so much the more pernicious in their application, as the interests of property are of less importance than reputation and life. It by no means follows, that a person, declared *non compos* by due process of law, is to be considered, on that account, merely, to be irresponsible for his criminal acts. This is a question entirely distinct, and is determined upon very different views of the nature of insanity, and of its effects on the operations of the mind, and, *here it is, that the lawyer encroaches most on the domain of the physician.*⁸³

⁸⁰ Isaac Ray, *A Treatise on the Medical Jurisprudence of Insanity* (Boston, Charles C. Little and James Brown, 1838), pp. xi-xii.

⁸¹ *Ibid.*, pp. 3-4.

⁸² *Ibid.*, p. 12.

⁸³ *Ibid.*, p. 14. Italics mine.

Ray objects to the nonclinical artificialities of lawyers: "It is very difficult to define the invisible line that divides perfect and partial insanity."⁵⁴ "That the mind, when meditating a crime, is less under the influence of disease, and enjoys a more sound and vigorous exercise of its powers, than when making a contract, or a will, few, probably, will be hardy enough to affirm; and yet the practice of the law virtually admits it."⁵⁵

Just as by refusing to recognize that there is a dividing line between total and partial insanity, Ray anticipated the modern concept of total personality, so did he foreshadow the modern views on the role of the emotions when he said, "Criminal acts, though abstractly wrong, may under certain circumstances become right and meritorious; and, if the strongest and acutest minds have sometimes been perplexed on this point, what shall we say of the crazy and distorted perceptions of him, whose reason shares a divided empire with the propensities and passions?"⁵⁶

Ray refers to Georget, for whom he has very great admiration. As a matter of fact, Ray originally thought of translating Georget, before he decided to write his own book on medical jurisprudence. He cites one of the cases related by Georget: "The fact of insanity having been given to the jury for decision, they returned that the accused acted *voluntarily* and with *premeditation*; and, secondly, that he was insane at the time of committing the act. This verdict, so consistent in reality, but so utterly contradictory in a legal sense, was received by the court and understood to mean, that the accused possessed the will of a madman, a merely animal will which excludes legal culpability. Had not the last question been raised, the accused, though mad, would have been condemned to death . . . It is one of those metaphysical subtleties, so prevalent on the subject of insanity, that the acts of an insane mind are *involuntary*."⁵⁷

Ray expresses "infinite preference" for the French law and disapproves of the English law which "sits in judgment on the measure of man's understanding."

The famous cases of the past, such as those of Hadfield, Bellingham, Arnold, are restudied briefly, and Lord Chief Justice Mansfield is taken to task, who "scarcely a dozen years after the absurdity of its principles had been so happily exposed in a few words, by Mr. Erskine, on the trial

⁵⁴ *Ibid.*, p. 15

⁵⁵ *Ibid.*, p. 21.

⁵⁶ *Ibid.*, p. 22

⁵⁷ *Ibid.*, p. 25.

of Hadfield," reverted to the old "metaphysical subtleties." "What a comment on the progress of improvement in the medical jurisprudence of insanity!"—exclaims Ray.

Ray pitilessly dissects the "right and wrong test" and exposes its psychiatric incongruity. Of the purely modern concept of individualization of all psychopathological reactions, he states: "The *particular* criminal act, however, becomes divorced in their minds from its relations to crime in the *abstract*."⁸⁸ The purely intellectual criteria of criminal acts are devoid of any meaning: "One, who is **not** practically acquainted with the habits of the insane, can scarcely conceive of the cunning which they will practise, when bent on accomplishing a favorite object. Indeed, it may be said, without greatly distorting the truth, that the combined cunning of two maniacs, bent on accomplishing a certain object, is always a match for the sagacity of any sound individual."⁸⁹

The outstanding feature of the *Medical Jurisprudence of Insanity* is Ray's espousal of the theory of moral insanity, to which he held fast throughout his life despite the fact that at one time he stood almost alone in American psychiatry on this question. His opponents were many; some of them were powerful, and some openly bitter in their opposition to Ray. The concept of moral insanity (which, as is known, was first formulated by Prichard in 1835) is historically and psychologically of great importance in psychiatry, for under this term the first appearance of the concept of psychopathic personality or neurotic character is marked. Ray's attitude toward moral insanity was more progressive and psychologically more sound than the corresponding attitude of present-day psychiatry toward the psychopathic personality or neurotic character. Psychiatry today is not inclined to consider the psychopath legally irresponsible; Ray considered moral insanity a sound cause for freedom from legal responsibility.

Ray reminded his contemporaries that mental disease is not and cannot be limited to disorders of intellect: "... It must not be forgotten, that the author of our being has also endowed us with certain moral faculties, comprising the various sentiments, propensities and affections, which, like the intellect, being connected with the brain, are necessarily affected by pathological actions in that organism."⁹⁰ Ray recalls Erskine's

⁸⁸ *Ibid*, p. 34

⁸⁹ *Ibid*, p. 44.

⁹⁰ *Ibid*, p. 48.

innovation when he introduced the principle that the presence of delusions frees one from legal responsibility on the grounds of legal insanity. This Ray considers insufficient. When the individual is afflicted with moral insanity and, "though perfectly conscious of what he is doing, [is] unable to offer the slightest resistance to the overwhelming power that impels him, the responsibility is to be considered not affected, because no *delusion* is present to disturb and distort the mental vision! In short, the very character that renders this mental disorder more terrible than all others, is also that which is made to steel the heart against the claims of humanity in behalf of its miserable victim."⁶¹

Years after Ray wrote these lines, his opponents—among whom the most formidable was the indomitable John P. Gray—felt that Ray was treading unsteady and morally dangerous ground. As is seen from the above, Ray's notion of moral insanity carried with it a full acceptance of the theory of the irresistible impulse, as well as a broader and extremely liberal and humanitarian understanding of what we of today might call the affective disorganization of the personality—of what D. Hack Tuke many years later wished to call "inhibitory insanity," or insanity in which the inhibitions usually present in normal civilized persons are disorganized. Such a broad conception of moral insanity could not but offend the sensibilities of those to whom the philosophic concept of free will was also an empirical, clinical fact, and who therefore were constrained to rise against such revolutionary, if not apostatic, ideas in psychiatry. How keenly this psychological insult was perceived could be judged by the fact that a man like John P. Gray was not only reprobatory about the concept of moral insanity but decidedly bitter and even rancorous. Although a member of the Reformed Church, he held fast to the theory of purely cerebral pathology and absolute free will, almost in the manner of an early Dominican.

To Gray the concept of moral insanity was decidedly repugnant, and not to him alone. The *Journal of Insanity*, commenting on the trial of Huntington, who was accused of forgery, stated: "If there be moral insanity anywhere, it is likely to manifest itself in Wall Street. The wonder is that it should never have been set up as a defense for the various iniquities committed there, until it was interposed in the case of Huntington."⁶² With equal directness if not as much sarcasm, Judge Lewis ex-

⁶¹ *Ibid.*, p. 49

⁶² *Am. J. Insanity*, XIV (1857-58), 110

pounded: "Moral insanity bears a striking resemblance to *vice*."⁸⁸ Judge Ludlow, charging the jury in the Freeth case (murder), said: "If by moral insanity is to be understood only a *disordered* or *perverted* state of the affections or moral powers of the mind, it cannot be too soon discarded as affording any shield from punishment for crime."⁸⁹

What characterizes the arguments about moral insanity is the prominence of passion, of the affective moral issues instead of scientific, psychological ones. This, as will be seen further, came out with particular distinctness in the Guiteau trial during which some of the experts were overtly recriminatory and angry when the question of moral insanity was brought up. This—almost fifty years after the appearance of Ray's *Medical Jurisprudence*. We may therefore conclude that the medical profession and the public were not only unready to accept Ray's views, but were still in a state of mind, or on that level of education, which permitted them to counter Ray's views with anger and rancor, as if he were attacking a sacred temple of truth with the sacrilegious expostulations of an ambitious and conceited new profession. As if to say: The metaphysical subtleties of the law may be modified to suit more modern medical language, but we may not and you new doctors may not broaden the field of legal irresponsibility; the guilty must be punished and not a single guilty person should be released merely because a physician insists that this person is mentally ill. As has been said, some physicians joined in this chorus, apparently they felt the need of being servants of the law more keenly than their own science warranted. Apparently, during that early transitional and formative state of psychiatry, the psychiatrist was as yet too insecure about the sociological role of his own science and profession, and he still sought security in almost unquestioning obedience to the law as it stood.

Although Ray's advanced position—foreshadowing by one hundred years the views of psychiatrists like William A. White and Bernard Glueck, or legal minds like Clarence Darrow and Sheldon Glueck—was new and isolated, the security of this contemplative, humanitarian psychiatrist was not affected.

With a dignified restraint which he would occasionally abandon to release a spark of fervor and almost religious scorn, Ray spoke:

The doctrine of moral insanity has been as yet unfavorably received by judicial authorities, not certainly for want of sufficient facts to support it, but

⁸⁸ *Ibid.*, XV (1858-59), 305.

⁸⁹ *Ibid.*, p. 304.

probably from that common tendency of the mind, to resist innovations upon old and generally received views. If, a quarter of a century ago, one of the highest law-officers of Great Britain pronounced the manifestation of "systematic correctness" of an action, a proof of sanity sufficient to render all others unnecessary, it is not surprising, that the idea of moral insanity has been considered by the legal profession, as having sprung from the teeming brains of medical theorists.⁶⁵

Gradually Ray permits himself to become a little more emphatic:

In the fulness of this spirit, Mr. Chitty declares, that, "unless a jury should be satisfied that the *mental faculties* have been *perverted*, or, at least, the faculties of reason and judgment, it is believed, that the party subject to such a *moral insanity*, as it is termed, would not be protected from criminal punishment"; and . . . At King's Cramond, Scotland . . . moral insanity . . . was declared by the court to be a "groundless theory." Such opinions, from quarters, where a modest teachableness would have been more becoming than an arrogant contempt for the results of other men's inquiries, involuntarily suggest to the mind a comparison of their authors with the saintly persecutors of Galileo, who resolved, by solemn statutes, that nature always had operated and always should operate in accordance with their views of propriety and truth.⁶⁶

Ray protests against the legal profession's search for a definition of insanity.

Jurists, who have been so anxious to obtain some definition of insanity, which shall embrace every possible case, should understand, that such a wish is chimerical, from the very nature of things. . . . It is not too much to insist, that facts, established by men of undoubted competence and good faith, should be rejected for better reasons, than the charge of "groundless theory."⁶⁷

Ray did not go so far as to ascribe all criminality to mental pathology, but, speaking of Great Britain and beyond doubt having also the United States in mind, he came to the conclusion that "the law of insanity, especially that relative to criminal cases, is still loose, vacillating, and greatly behind the present state of the knowledge of that disease."⁶⁸

To use one of Ray's expressions at this point, "if the remarks seem to be unnecessarily prolix it can only be observed by way of excuse" that the importance of Ray's ideas on the subject cannot be overestimated. Not only did he surpass in vision and daring all his contemporary

⁶⁵ Isaac Ray, *op cit*, p 49

⁶⁶ *Ibid*, pp 49-50

⁶⁷ *Ibid*, pp 50-51.

⁶⁸ *Ibid*, p 54

colleagues, but the validity of his views is so solid and profound even today that many of his sound recommendations are still very far from realization, although many of his successors have been working along the lines he delineated one hundred years ago.

Ray's views on juries in criminal cases in which the plea of insanity is interposed are fresh and daring. He says that juries are "manifestly unfit" to solve the question of insanity in a criminal case. For a jury "to decide a professional question of a most delicate nature and involving some of the highest interests of man, is an idea so preposterous, that one finds it difficult, at first sight, to believe that it ever was seriously entertained."⁶⁹

Expert witnesses should be real experts, for "a medical man may spend a life of full practice, without having been intrusted with the care of a dozen insane persons." Only competent, experienced psychiatrists (Ray does not yet use this term) should be called upon to be witnesses in court. The courts are very deficient in this respect. "If they [the members of the jury] are obliged to decide on professional subjects, it would seem but just and the dictate of common sense, that they should have the benefit of the best professional advice. This, however, they do not always have; and, consequently, the ends of justice are too often defeated by the high-sounding assumptions of ignorance and vanity."⁷⁰

Experts should examine the accused, as they usually do in France. Ray cites a very telling story to demonstrate the unreliability of juries in medical matters: "Many readers may recollect, that, in the case of Donellan, tried in 1781 for the murder of Sir Theodosius Boughton, by poisoning, the opinions of three or four physicians, as unknown to fame, as the science they professed to understand seems to have been unknown to them, far outweighed with the court, that of John Hunter, though illustrated by his various learning, and supported by his reputation for unrivalled talents and original research."⁷¹

This is the substance of Ray's "Preliminary Views," which he follows up with many chapters of detailed clinical descriptions of the various psychopathological conditions known in his day; each clinical entity is then reviewed from the point of view of legal (civil and criminal) implication. There is perhaps reason to experience a certain melancholy in the perusal of this work, one hundred and five years old at this writing.

⁶⁹ *Ibid.*, p. 57.

⁷⁰ *Ibid.*, p. 59.

⁷¹ *Ibid.*, p. 61.

It is admirable to see how the contemplative perspicacity of Isaac Ray penetrated through the century and enabled him to formulate many of the problems which psychiatry of today is still struggling with while the law still stands as firm as of yore. The law still uses the right and wrong tests; it still is lax and rather unintelligent as far as expert testimony is concerned, it still has juries decide the question of sanity. It is not difficult to understand why there was a note of melancholy in the sturdy and trenchant words of Ray at the conclusion of the "Preliminary Views."

The dominant philosophy has prevailed so long and so extensively, and has become so firmly rooted in men's minds, that they who refuse to take it on trust and seriously inquire into its foundations, and after finding them too narrow and imperfect, are bold enough to endeavor to remedy its defects by laying foundations of their own, are stigmatized as visionaries and overwhelmed with ridicule and censure. . . . So true it is, that, in theory, all mankind are agreed in encouraging and applauding the humblest attempt to enlarge the sphere of our ideas, while, in practice, it often seems, as if they were no less agreed to crush them, by means of every weapon, that wit, argument, and calumny, can furnish. In the course of this work, the reader will have frequent occasions to see how the popular misconceptions—which are too much adopted by professional men—of the nature of various forms of mental derangement, have been produced and fostered by the current metaphysical doctrines, and thus may have some means of judging for himself, how far the imperfect notions of insanity, that are yet prevalent, may be attributed to the cause above assigned.

Ray's truly noble scorn was not dictated by sentimental philanthropy of spirit, but rather by true conviction that the clue to the secrets of abnormal and antisocial behavior is to be found not in the formalistic technicalities of the law but in the scientific investigations of mental disease. From this thought Ray derived his inspiration and perseverance, and it was with both inspiration and perseverance that he joined, as one of the Original Thirteen, the efforts to further the work of the new Association. He was at once recognized by his colleagues as the authority on the legal aspects of psychiatry.

Ray's authority and leadership of course did not remain unchallenged. Although most of his opponents were younger than he when in the seventies and the early eighties they challenged him, in matters of legal and psychiatric aspects of crime they represented the older trends—they pulled

⁷² *Ibid*, pp 66-67.

toward the past. But in the middle forties Ray's strictest censures of the criminal law as it existed were on the whole accepted by the profession. The *Journal* published reports of criminal cases in every volume. These reports contained expert testimony of the majority of the Original Thirteen, who frequently testified in court. The general spirit was that of cooperation with the law, but also of educating the lawyer, whose "teachableness" seemed at the time rather high, considering the proverbial refractoriness of the lawyer, who since Coke and Lord Hale had seemed unable to assimilate anything psychiatric that was new.

The issue of moral insanity and the problem of the irresistible impulse as an excuse of crime, or bar to punishment, were conspicuous in the discussions of the time.

In 1884, D. Hack Tuke read a paper on "Moral Insanity" before the British Medical Association at Belfast, and one year later he spoke before the Medico-Psychological Association at Cork on a "Case of Congenital Moral Defect." To those meetings Tuke brought a letter which Prichard had written to Tuke's father as early as 1834, inquiring whether there were any cases of moral insanity to be observed at the York Retreat. "By that term," Prichard explained, "I distinguish the mental state of persons who betray no *lesion of understanding*, or want of the power of reasoning and conversing correctly upon any subject whatever, whose disease consists in a *perverted state of the feelings*, temper, inclinations, habits and conduct." Prichard's explanation is the earliest and most precise description of moral insanity.

Some time in 1891 Tuke published an extended essay on Prichard and Symonds, to which were appended the above-mentioned papers. The *Journal's* reviewer took notice of this publication in a manner of respectful irony. He stated that all that Tuke had expounded on moral insanity was "important, if true," and frankly came to the core of the matter by stating: "The truth is, that which has made definite conclusions so difficult to be reached on this whole subject, though science is supposed not to be deterred by consequences, or to take account where psychological dynamite may fall upon society, is the question of *responsibility*, and the obvious abuses that may creep in from this source to the administration of justice in our courts of law."⁷⁸ The *Journal* further chided Tuke and Professor Maudsley for showing "a little more heat toward lawyers and judges than one might expect to find in the 'dry light' of science."

It is to be noted that this rather transparent rejection of the theory

⁷⁸ *Am. J. Insanity*, XLVIII (1891-92), 406

of moral insanity was expressed almost exactly half a century after Ray first offered it to the American reader. The argument used against this theory, while scientific in appearance, was yet colored by the obvious concern of the psychiatrist for the proper administration of criminal justice and for the problem of the defendant's responsibility. It took a greater number of years than one would have wished for the psychiatrist to free himself from the confusion of his scientific conscience and duty and the inner demands of his civic conscience, which he must keep under absolute control if he wishes to avoid the risk of becoming merely a servant of legal traditions. The psychiatrist today is not yet entirely free of this civic temptation and scientific confusion, but sixty to seventy-five years ago this failing was more frequent and was looked upon more often as a virtue. Thus, in the trial of one George Hammond in 1857, Dr. W. S. Chipley, superintendent of the Lunatic Asylum in Lexington, Kentucky, appearing as an expert witness, testified plainly: "He was in my opinion irresponsible."⁷⁴

Moreover, the word "insanity" carried with it the connotation of "mental disease," with the emphasis on disease and a further accent on the pathology of the brain. When Dr. Walter Kempster, superintendent of the Northern Hospital for the Insane in Wisconsin, testified in the case of the murder of President Garfield, he had no doubts as to the extreme correctness of his opinion, and in this he reflected the opinion of the whole profession of his day. Said Dr. Kempster at the Guiteau trial (1881): "In every case of insanity there is disease of the brain which may be discovered if the proper methods are made use of to discover it. I have never yet examined a case in which I did not discover marked disease of the brain" (*sic*).⁷⁵

It is this unfortunate, but for the bearer thereof happy, conviction that made John P. Gray, the "star" witness for the prosecution at the Guiteau trial, say, "Inasmuch as I, in my view, can not conceive of any moral act, or the exercise of any moral affection, without an intellectual operation or mental action accompanying it, so I can not possibly dis sever this mental unity."⁷⁶ These men were unable to fathom a psychopathology of affects, and consequently they joined hands with the oldest tradition of the law and stressed the intellectual components only. Problems involving the psychology of emotions and moral reactions made them more

⁷⁴ *Ibid.*, XVI (1859-60), 179-181

⁷⁵ *Ibid.*, XXXVIII (1881-82), 384

⁷⁶ *Ibid.*, p. 425.

impatient than curious and more dogmatic than investigative. As a result, they were driven at times into very singular intellectual corners, from the affective cobwebs of which they had somehow to extricate themselves.

It was this welter of contradiction which led Dr. A. E. Macdonald, himself a superintendent of a hospital for the insane (New York City), professor of medical jurisprudence in the University of New York, and later president of the American Medico-Psychological Association, to utter this incongruity at the Guiteau trial: "I do not believe in it [moral insanity] myself. I have never seen a case. Moral insanity is another name, and has been from the time of its invention, for wickedness or depravity. Its first use, I believe, was at the time of the French Revolution [*sic!*] and it was meant to excuse the slaughter that took place then."⁷⁷

One might almost gain the impression that on the question of moral insanity Ray stood alone in American psychiatry. This would not be entirely correct. Not only certain psychiatrists but even some courts saw merit in the concept of moral insanity. Judge Gibson, although with caution and definite qualifications, yet recognized it when he said in 1846: "But there is a moral or homicidal insanity, consisting of an irresistible inclination to kill, or to commit some other particular offense."⁷⁸ A matron of Mount Pleasant State Prison, Sing Sing, New York, published an instructive "Case of Destitution of Moral Feelings" in which she described a prisoner in the following words: "She was a most wonderful liar in word as well as deed. In the former she was if possible more artistical than in the latter."⁷⁹ Judge Edmonds of New York, taking part in a discussion on moral insanity which was held in the New York Academy of Medicine in 1862, stated that he was much impressed and convinced by Ray's *Medical Jurisprudence of Insanity*, and he claimed that he had been the first to recognize the doctrine of moral insanity in legal practice when he was trial judge in the case of Kleim in 1845. Kleim was tried for murder, acquitted on the grounds of insanity (Pliny Earle was one of the witnesses), and committed to the Utica Hospital.

The claims of Judge Edmonds⁸⁰ were not entirely justified. He was undoubtedly an enlightened, progressive judge and very sympathetic to

⁷⁷ *Ibid.*, p. 372.

⁷⁸ Cited by Henry Weihofen, *Insanity as a Defense in Criminal Law* (New York, Commonwealth Fund, 1933), p. 49.

⁷⁹ *Am. J. Insanity*, III (1846-47), 129-135.

⁸⁰ *Ibid.*, XVIII (1861-62), 404 ff.

psychiatry. In his discussion of Dr. Parigot's paper "On Moral Insanity in Relation to Criminal Acts" he undoubtedly expressed his agreement with the concept of moral insanity but, as Dr. D. Tilden Brown pointed out and as is seen from the 1846 report in the *Journal of Insanity*, Judge Edmonds in his charge to the jury at no time mentioned, or even alluded to, moral insanity.

Evidently the issue remained unsolved in the minds of many psychiatrists as well as in some of those of the very few progressive jurists. The discussion revolved around purely formal points. At times people objected to the term as unfortunate, or to the psychological principle involved, but usually there was more acrimony than critical judgment in the discussion. It is well to emphasize that the law and psychiatry (which latter, in the words of Judge Edmonds, was at the time so advanced that it was "almost a branch of medicine") coöperated in this aspect of intolerance. The editors of the *Journal* insisted that "For all legal purposes, it seems idle to suffer the special defense of *moral* insanity. The substantive term is sufficient, without the adjective qualification; and the qualification besides is too shadowy, fluctuating, indefinable, and disputable, to be firmly grasped by the law, and fixed by that precise definition which is necessary to make a 'rule of action,' which the law is defined to be, and without which it can not be *law*."⁸¹

Thus one might be justified in saying that after a very brief moment of liberalism toward psychology the leading psychiatrists of the first few decades after the founding of their Association, with only rare exceptions, reverted to the principle of being servants of the law as it stood. There was little if any discussion of possible reform of the procedural aspects of the criminal law, and less about the spirit of it. The adjective as well as the substantive law was accepted by psychiatry with almost unquestioning compliance, and psychology was barred from intruding into legal chambers.

When James Rogers, a youngster, became intoxicated and committed a murder in the city of New York some time in 1858, the editorial reporters of the *Journal* stated with some heat that there is no such thing as a boy in the eyes of the law.

There are real boys still in some unprogressive countries; on the continent of Europe, and in England. They go to school in Eton yet; but here, all who go

⁸¹ *Ibid*, XIV (1857-58), 319

to school are infants, or young ladies and young men No boys go. According to the old classification, however, Rogers was, in truth, a mere boy. His associates were of the same stamp. But, as boys will sometimes, they "put an enemy in their mouths to steal away their brains", and under the influence of the enemy, the boy Rogers, without provocation, stabbed the old man Swanston, with his pocketknife. It resulted in death, and was a murder, for which he was properly convicted and executed.⁸²

The psychiatrist stands out here not only as a moralist but as a district attorney, and therefore he becomes skeptical even about his own medical field: "In these days of confusion and looseness of ideas in respect of morals and crime . . . perhaps it is hardly to be wondered at, that when habitual drunkenness is elevated, by some high authorities, to the scientific distinction of *mania*,—to wit, *Dipsomania*,—mere casual intoxication should be deemed a sufficient defense for so venial a crime as murder."⁸³

The editors congratulated the court for being "worthy of the bench," for the "clearness and legal bearing, of the consummate lawyer and wise judge." The court's

. . . law cannot be gainsayed; and although we have the humanity to sympathize with the victim whom it consigned to death, we are disposed to think it, in a general aspect, a subject of congratulation, that the prevailing wildness of youth should be checked by an awful example, showing that neither boyhood, nor the freaks of intoxication, are to receive sympathy from legal tribunals, or to be indulged in violence and crimes under the favor of a loose and misguided construction of the acts committed under their impulses⁸⁴

As the editors put it in connection with another murder case a few years later, "Still, psychological science has its practical value, in aiding the natural sense by which the awards of human justice are directed."⁸⁵

I have devoted so much attention to and quoted so extensively from the obviously antiquated views which prevailed among psychiatrists for so many years, not in order to judge and still less to condemn them, but rather to appraise them in the light of historical perspective. It can thus be seen that what we call today "the legal aspects of psychiatry" is really a recent development. The cultural and ideological climate of the first half of the century of the Association was in many respects much more progressive than the legal ideology of the early psychiatrists. It was the

⁸² *Ibid*, XV (1858-59), 259

⁸³ *Ibid*, pp. 258-259.

⁸⁴ *Ibid*, p. 260.

⁸⁵ *Ibid*, XX (1863-64), 417.

task of these early psychiatrists to break down the general prejudice as to mental disease. They assumed the task with earnest humanity and broad sympathy, but there was no general psychology or sociology for them to espouse. And if there had been, it is doubtful whether psychiatry would have been able to adopt them, for only profound understanding of mental disease leads to a grasp of the more pressing and complex psychological and sociological problems. And this understanding was as yet immature; only the physical setting and organization prerequisite for study and ultimate understanding were being perfected in those truly pioneer days of psychiatry.

From this point of view, another phenomenon acquires even greater historical interest. I have in mind Isaac Ray's advanced views and his perseverance in almost single-handed proselytism of the theory of moral insanity. When almost twenty-five years had passed since he published his *Medical Jurisprudence of Insanity*,⁸⁸ and it had gone through four editions, he still stood alone. The opinion of the fifteen English judges in the McNaghten case had appeared in the meantime and almost at once had taken hold on American criminal jurisprudence. In later editions Ray incorporated into his book a few telling criticisms of the McNaghten formula, but his position remained isolated.

The *Journal of Insanity* gave Ray a hearing in 1861, when it published his "An Examination of the Objections to the Doctrine of Moral Insanity." Ray had lost none of the strength of his convictions, none of his fire. "Some of those," he said, "most capable, it might be supposed, of appreciating the labors of Pinel, Esquirol, Marc, Georget, Combe, Conolly, Prichard, Winslow, Bucknill and Guislain, do not hesitate to hold up these men as believers in a doctrine destitute of foundation and dangerous to society. If this were a matter of scientific curiosity merely, it might be very properly left to the ordinary progress of knowledge, which finally sets at rest all questions of fact; but its practical consequences to life, liberty and property, require that it should be settled speedily."⁸⁹

Ray's argument is suffused with reproach and reproof:

It is mortifying to our professional pride to see men who ought to consider themselves as the ministers and interpreters of nature, rejoicing in their glorious office and receiving her revelations in a glad and teachable spirit, on the contrary, turning away from them with a feeling of scorn because they conflict with some preconceived notions of their own. There is brought to their notice

⁸⁸ *Ibid.*, XVIII (1861-62), 113.

an order of facts both numerous and well-authenticated, exhibiting a common incident or quality of a highly important character. But it affords no satisfaction to them. They do not ask if the facts are true, if the conclusions are legitimately drawn. They care for none of these things. It is enough for them that, in their opinion, the tendency is bad, and upon their short-sighted views of the moral consequences of a scientific conclusion, they presume to decide whether it is true or false."⁷⁷

The central point of Ray's paper, which is twenty-six pages long, is not new. It revolves around the recognition of feeling, or emotions, as susceptible of pathology without the impairment of the intellect. It is a recapitulation of what had been said before about *manie sans délire* after Pinel introduced the term. The most important aspect of Ray's paper is not so much its clinical and psychopathological exposition as the constant—if more implied than overt—stress laid on the evaluation of the role of human social conduct on the basis of its manifestations and not on the basis of preconceived, affective, or formal morality. Ray refuses to be a psychological scientist who is at the same time a preacher and a judge; there is the spirit of the liberal and libertarian New Englander in his pen. He concludes his paper by saying

"If in the course of my remarks I have occasionally manifested a little more freedom of expression than the needs of a strictly scientific discussion require, I can only say in excuse that I did not begin it. Facts may be met by facts, arguments may be met by arguments, but sneers, jibes, sophisms, and conceit, must be encountered with a very different class of weapons."⁷⁸

The discussion of moral insanity lingered on, so to speak, for another twenty years, and then it imperceptibly died out. One of the last treatments of the subject was that of Dr. J. Workman of Toronto.⁷⁹ Dr. Workman's argument was rather tenuous. He objected to the term "moral insanity" and suggested that it be substituted by the term "insane morality." Workman attempted to decide the question of moral insanity by a majority vote, in so far as he pointed out that out of "forty representatives of the United States and Canadian Asylums . . . only two or three declared their belief in the actuality of moral insanity. . . . And now, Mr. President and gentlemen, in closing, perhaps the last address I shall ever have the privilege of uttering in your presence, I would earnestly ad-

⁷⁷ *Ibid.*, p. 126.

⁷⁸ *Ibid.*, p. 138.

⁷⁹ "Moral Insanity—What Is It?," *Am. J. Insanity*, XXXIX (1882-83), 334-348.

monish you against ever, in a court of justice, using the term *moral insanity*."⁹⁰

When a discussion is alleged to be or is actually being conducted on a high scientific plane and it gradually degenerates into a battle of words, and when attempts begin to be made to solve the problems involved by means of terminological changes and adjustment—one can be safely certain that this discussion was terminated long before the voices of the debaters were silenced, and that no solution was attained. When the subject is dropped, the impression is gained that it was all but an episode of no great consequence and deserves to be respectfully forgotten or, if recalled, recalled as an ephemeral curiosity of an unenlightened age. That this is not always so is overlooked. It was not so as far as the issue of moral insanity is concerned. That it seems to have been forgotten, is true, but its importance is still to be appreciated by our own generation of psychiatrists, whose attitude toward crime has changed so radically in the last twenty-five years.

Aside from its essential importance, we should recall that the question was intimately interwoven with the issue of the irresistible impulse. Judge Gibson spoke of moral insanity, which he equated with homicidal insanity; Judge Edmonds referred to moral afflictions, which he thought somehow affected the rational part of man and his will, so that his impulses became uncontrollable. Judge Shaw made a most solid contribution to the problem. The decision of these judges and of a few like them in the early days of organized psychiatry might well have foreshadowed a new era in what is called criminal justice. The liberal lawyer and the psychiatrist fathomed perhaps more intuitively than intellectually that man is not reason and action alone, and that the secret of man's behavior may well some day be found in his passions, which make him reason without being reasonable and act voluntarily without actually being willing. Yet because this prophetic, intuitive perception seemed to be connected with an attitude of what some called "dangerous philanthropy," because it implied the acceptance that our moral sense might also become perverted, insane—both the jurist and the psychiatrist were inclined to feel that if they followed the logic of their psychological hypothesis they might be suspected by others, or they might suspect themselves, of being tempted to shirk the responsibility of considering man responsible for his crimes.

⁹⁰ *Ibid*, pp. 341, 348.

This frequently unspoken anxiety permitted the issue of moral insanity to fade out as one of the focal problems in American criminal jurisprudence. Judge Gibson, in his decision in the case of the Commonwealth *vs. Mosler* (1846), expressed this unspoken anxiety very tersely when he said: "There may be an unseen ligament pressing on the mind, drawing it to consequences which it sees, but cannot avoid, and placing it under coercion, which, while its results are clearly perceived, is incapable of resistance. The doctrine which acknowledges this mania is dangerous in its relations, and can be recognized only in the clearest cases."⁸¹

All this was judicious and good, but the trouble was and is that the clearest of such cases are very obscure and not easily, if at all, demonstrable in the procedural vise of the criminal law in relation to mental illness. Some in the psychiatric profession persevered; they saw in the doctrine of the irresistible impulse the most powerful wedge which could be driven into and split the petrified log of traditional criminal law. But there was no unanimity among psychiatrists on this issue, either. And so it came to pass that when the *McNaghten* case became the basis of criminal law in relation to the issue of insanity in England, it was "followed by the current of American adjudications," as an associate justice of the Supreme Court of Alabama put it. Twenty-nine states of the Union follow the *McNaghten* case today.

As to the irresistible impulse, it crept in, so to speak, here and there, but it never gained the popularity it deserved. In 1863 Illinois recognized it as an excuse of crime. In 1920 it was still recognized, even if the accused knew the difference between right and wrong. Some thirty-five years previously, however, Justice Somerville ruled that even if the accused did possess the ability to distinguish between right and wrong, but under duress of mental disease "had so far lost the power to choose between right and wrong, and to avoid doing the act in question, as that his free agency was at the time destroyed,"⁸² the accused should be deemed not legally responsible.

Justice Somerville, in this case of *Parsons vs. the State* (of Alabama) in 1886, incidentally made another pronouncement of prime importance. The whole question of the relation of insanity to criminal law, the *quaestio vexata* of psychiatry as Pliny Earle called it, was so difficult not so much because our psychiatric knowledge was still deficient but primarily

⁸¹ Quoted by Weihofen, *op. cit.*, pp. 49-50.

⁸² *Am J Insanity*, XLIV (1887-88), 443.

because the law was rigid under the perennial hold of *stare decisis*. Justice Somerville had some instructive pronouncements on the subject: "The inquiry must not be unduly obstructed by the doctrine of *stare decisis*, for the life of the common law system and the hope of its permanency consist largely in its power of adaptation to new scientific discoveries, and the requirements of an ever advancing civilization. It is not like the laws of the Medes and Persians, which could not be changed."⁸⁸

Yet only seventeen states of the Union recognize the irresistible impulse as a legitimate plea today. Moral rather than scientific sensibilities are responsible for the prevalence of the right and wrong test—the test to which Ray objected in 1838, and which Sir James Stephen forty-five years later considered among the "antiquarian curiosities" of the law.

Dr. Gould, who as early as 1847 wrote a report to the Legislature of the state of New York on capital punishment,⁸⁹ was inclined to believe that the right and wrong test was untenable. He related that a survey in his own hospital had disclosed "that with scarcely an exception, its inmates had clear ideas of right and wrong and of the distinction between them; the same test has been applied in many of the asylums of our country, and the result has been, that not more than ten per cent of the whole number would be exempt from legal responsibility under its operation, and these were so furiously mad as to be manifestly dangerous to be at large."

The editors of the *Journal* in that year were inclined to believe that the right and wrong test was merely an importation from England: "It is singular indeed for judges in this State to instruct juries, not in the words of our own statute, but according to what they may suppose to be the law of England, and to establish as a test of insanity, 'inability to distinguish right from wrong,'—a test alike unknown to our statute, and to truth and justice."

But, say [the state judges], the statute does not define insanity, it does not say what it is, and we cannot trust to the common sense and intelligence of the jury to determine what it is, even if aided by the testimony of medical men, and those practically acquainted with this disease, but we must go back and ascertain what a certain set of men who lived centuries since in an ignorant age, and who knew nothing of insanity, thought to be its symptoms and nature, and whatever they thought and said on this subject, *the jury must receive as law*. Surely this passes even beyond absurdity

⁸⁸ Weihofen, *op. cit.*, p. 61.

⁸⁹ *Am. J. Insanity*, IV (1847-48), 31-39.

⁹⁰ *Ibid.*, p. 71.

These were strong, and enlightened, words. As I have repeatedly pointed out, the first years of the Association were marked by a militant, progressive attitude with regard to the legal aspects of insanity. Crime and the legal relations of the insane were in the forefront of the early psychiatrists' interests, and these interests found expression in the first official steps to establish psychiatric education in medical schools. The first chair of psychiatry in America was established early in the first decade of the Association, theretofore medical jurisprudence had been linked with "chemistry," which meant toxicology, but Samuel M. Smith, who for several years was assistant physician at the Ohio Lunatic Asylum, was appointed to the faculty of Willoughby University at Columbus, Ohio, in 1847 and given the title of Professor of Medical Jurisprudence and Insanity.

As time wore on the editor of the *Journal* himself, this time Dr. Gray, found little quarrel with the criminal statutes and procedures of his time. Gray did not object to the right and wrong test, which ultimately established itself firmly in this country, and he opposed the principle of the irresistible impulse. The right and wrong test remained entrenched in the United States, in England, and throughout the British Empire. In England Russell Gurney's bill of 1874 recommending the recognition of the irresistible impulse was rejected. Several papers presented at the Inter-Colonial Medical Congress at Sydney, N. S. W., in September, 1892, still dealt with this *quaestio vexata* and were published in the *Journal of Insanity*.

W. W. Godding, speaking before the Psychological Section of the International Medical Congress in Washington in 1887, said: "I shall not live to see it, but he who writes the judicial history of the twentieth century will record the abolition, among English speaking nations, of my Lord Coke's venerable dogma of a knowledge of right and wrong as a test of criminal responsibility in the insane."⁸⁸ Recalling these his own words about one year later, Godding said, "I said then I should not live to see it—says Benedict in the play, 'When I said I would die a bachelor I did not think I should live till I were married.'"

Godding was pleased with a new decision made by Judge Montgomery, in which the latter followed Justice Somerville of Alabama. But Godding's renewed although reserved optimism still stands unjustified by harsh realities. So deeply rooted is the right and wrong test that even in

⁸⁸ *Ibid.*, XLV (1888-89), 191.

cases in which delusions are present, the courts more often than not follow the McNaghten rule and think the accused responsible, if the crime would not be justified were the delusion a real fact. Even such an enlightened and liberal jurist as Justice Cardozo found himself hampered in thought when considering this question in *People vs. Schmidt* (1915). He ruled: "A delusion that some supposed grievance or injury will be redressed, or some public benefit attained, has no such effect in observing the moral distinctions as a delusion that God himself has issued a command. The one delusion is consistent with knowledge that the act is a moral wrong, the other is not."⁸⁷

The legal mind insists on measuring even delusions by the yardstick of alleged good reasoning, which the deluded must theoretically employ to satisfy the law. The words of Isaac Ray uttered in this connection over three-quarters of a century before, in one of the later editions of his *Medical Jurisprudence*, are still pertinent and alive:

This answer [of the English judges regarding delusions] is certainly very plain and it must be reasonable, too, *if insane men would but listen to reason*! This is virtually saying to a man, "You are allowed to be insane; the disease is a visitation of Providence, and you cannot help it; but have a care how you manifest your insanity, there must be method in your madness. Having once adopted your delusion, all the subsequent steps connected with it must be conformed to the strictest requirements of reason and propriety. If you are caught tripping in your logic; if in the disturbance of your moral and intellectual perception you take a step for which a sane man would be punished, insanity would be no bar to your punishment. In short, having become fairly enveloped in the clouds of mental disorder, the law expects you will move as discreetly and circumspectly as if the undimmed light of reason were shining upon your path."⁸⁸

He who writes the judicial history of the twentieth century will have to record that in the last decade of the first half of that century my Lord Coke's venerable dogma of a knowledge of right and wrong as a test of criminal responsibility in the insane still seems to stand the test of time, although it has long since failed to withstand the test of scientific psychopathology.

The right and wrong test is not the only persistent leftover of the remote past which the scientific psychiatry of the twentieth century con-

⁸⁷ Weihofen, *op. cit.*, p. 41.

⁸⁸ 4th ed., pp. 46-47.

tinues to combat with the same energy and hope with which many of the psychiatrists of the nineteenth were inspired. The hypothetical question is another of those "legal monstrosities" which have been and are being combated, thus far without much success. To the psychiatrist the hypothetical question is a procedural form of self-deceit, an artifice and incongruity both logical and psychological. It is well to remember that it is usually with the answer to the hypothetical question that the expert witness is turned over to the opposing side, to be exposed and subjected to the iniquities to which the psychiatric expert is traditionally subjected and which are almost invariably displayed by the contending parties for the questionable benefit of the court and jury. The hypothetical question still stands, and so do the iniquities in relation to expert witnesses.

As early as 1853, a serious attempt was made to formulate a rational scientific plan for the organization of expert testimony. William H. Stokes published a paper "On a Court of Medical Experts in Cases of Insanity."⁹⁹ But this project (apparently influenced by the practice in France), suggesting that in each state or district "a board of commissioners of experts" be established by law, never went beyond its publication. There were many heated discussions on the subject. The courts were justly accused of not establishing any standard for expert testimony, and for accepting any physician as an expert. The psychiatric profession was not less critical of the behavior of some of its own brethren in court. H. C. Wood, appearing before the Philadelphia Jurisprudence Medical Society, said: "In the eyes of the court these men are all experts, to the play of whose ignorant fancy human property, liberty and life are left almost unprotected. . . . Trials involving the question of insanity are fast becoming such a farce in this country that he who sees them as they are, hardly knows whether to laugh or to cry."¹⁰⁰

When the subject of expert testimony was brought up at the meeting of the Association in 1888, few words were minced; the problem is still unsolved. It is perhaps quite in order to recall that in 1909 Britton D. Evans, in "Court Testimony of Alienists," spoke in favor of the abolition of the hypothetical question and felt constrained to quote Macaulay's "Essay on Bacon": "We will not at present inquire whether the doctrine which is held on this subject by English lawyers, be or be not agreeable to reason and morality—whether it be right that a man should with a wig

⁹⁹ *Am. J. Insanity*, X (1853-54), 112-122.

¹⁰⁰ *Ibid.*, XLI (1884-85), 476.

on his head and a band around his neck, do for a guinea what, without those appendages, he would think wicked and infamous to do for an empire."¹⁰¹

The status of expert testimony, of the hypothetical question, and of the general position of psychiatry in criminal cases was well illustrated by the confusion of psychological and moral tongues and the acrimony at the Guiteau trial in 1881, as well as by the psychiatric discussions which followed the adjudication of the case.

During the more than sixty years which have elapsed since that famous trial a number of changes have occurred. Gradually, almost imperceptibly, the spirit which characterizes the ideas of Isaac Ray was revived—with greater psychological knowledge, better organizational tools, and greater professional *esprit de corps* than existed in the days of Ray.

The Guiteau case, of which a most detailed report appeared in the *Journal*,¹⁰² demonstrated that psychiatry had not outgrown the need of serving the law in the latter's spirit and procedure, and that the psychiatrist more frequently than not identified himself with the court and jury, if not with some of the contending lawyers. It is this identification that the psychiatrist had to outlive, and in order to outlive it a considerable amount of learning and inner transformation was required. The older attitude persisted, although not in such concentrated form, for some years. As late as 1888 Judson B. Andrews, superintendent of the Buffalo State Asylum, concluded his medico-legal paper with an attack on Spitzka, whom he quotes as saying: "In all cases of inebriate criminals there is mental defect and incapacity either to reason sanely or to control their acts. An inebriate who does criminal acts cannot be of a sound mind. A criminal who is an inebriate is not sane. No inebriate is fully sane and no criminal can be of sound mind long." To this Andrews responds: "By this standard, inebriety and criminality are but the evidences of insanity, and the more demoralized the drunkard and the more hardened the criminal the less responsibility for his acts. Such theories of medical jurisprudence may capture the sentimentalist and the pseudo philanthropist, but they will not commend themselves to the sober judgment of the medical profession, nor satisfy the demands of law and justice."¹⁰³

¹⁰¹ *Ibid.*, LXVI (1909-10), 93.

¹⁰² *Ibid.*, XXXVIII and XXXIX.

¹⁰³ "The Case of Peter Louis Otto—a Medico-Legal Study," *Am. J. Insanity*, XLV (1888-89), 220

And even more than twenty years after these words of reproof were written, we find Sanger Brown reporting (1909) one of his experiences in court in a case of arson, where the defendant, a woman, pleaded insanity: "The whole community, pretty much, with the exception of the State's attorney and one or two of his assistants, were in favor of the defendant. . . . The lawyer who defended her was postmaster of the country town, and had the local profession testify in her favor, so that if I had been denied the privilege of taking up the evidence witness by witness and analyzing it in my own way before the jury, the defendant undoubtedly would have been acquitted. But after a few hours of patient explanation I was able to turn the tide and the defendant was promptly convicted."¹⁰⁴

Sanger Brown's remarks bring into focus the two most salient problems which revolve around the psychiatrist's attitude toward crime and the criminal. The first problem is: how much should a psychiatric expert in a criminal case be for or against any side? Is not his professional calling of such a nature that he should at least try to remain neutral? The second problem: to what extent does the special knowledge of the psychiatrist allow him to remain an adherent of the old system of purely primitive justice?

The first problem, the one involving the partisanship of the expert, or at least the willingness of the psychiatric expert to join one or the other party in the procedural constellation of a criminal trial, remains unsolved. Consequently, the problem of expert testimony, the problem of whom the court, the prosecution, and the defense may consider an expert, the problem of how to avoid the appearance in a criminal trial of those whom Clarence Darrow called "testifiers" with all the scorn and civic exasperation of which that great lawyer was so capable—all these problems also remain largely unsolved.

As for the second question, that experienced and earnest psychiatrists seek to snatch the confirmed criminal out of the hands of justice is a common belief, and it feeds the general suspicion of and even contempt for the psychiatrist on the part of the public and judiciary. Apparently the prejudice inherent in this belief is responsible for the propensity to use "testifiers" instead of scientifically qualified men. That this prejudice against psychiatrists is not justified by facts is amply proved by the report

¹⁰⁴ *Am. J. Insanity*, LXVI (1909-10), 100.

of the Committee on Medical Expert Testimony, which was submitted to the Association in 1910 at its sixty-sixth annual meeting.

In reply to inquiry on this point the superintendents of 75 out of 108 hospitals in this country and Canada, with a population of over 83,230 inmates, report but seven criminals who had been charged with homicide who had been improperly adjudged insane and sent to hospitals for the insane during the past two years. Superintendents of special institutions for the criminal insane report that very few criminals of any kind are wrongly adjudged insane and committed to their institutions—not a dozen in twenty years according to Dr. Lamb of the Matteawan institution for this class—while the period of hospital residence of discharged cases shows that *they underwent a longer confinement as insane patients than would have followed had the same men been convicted and sent to prison.*¹⁰⁶

The report of the Committee, which was headed by Henry R. Stedman, observes that “the legal injustice in this matter is that the insanity defence is not by any means employed as often as it should be. In other words, much more harm results from *lack* of expert testimony than from its defects.” It also cites “MacPherson, a Scotch authority,” who believes that “hitherto the law has certainly erred on the side of severity and has hanged ninety-nine irresponsible persons for one responsible person who has escaped on the plea of insanity.” A striking fact is related: “Dr. Allison has reported that 53 per cent of 179 insane persons who had committed murder and who were under his charge at the asylum for the criminal insane at Matteawan were received from prisons to which they had been sentenced for life.”¹⁰⁶ Opposition to the right and wrong test of legal responsibility and to the hypothetical question is reiterated. Little, the report says, is expected from purely procedural reform. The profession itself should assert its needs and carry out the necessary reform. Sir James Stephen, who was of the same mind, is cited.

There is a reminder of the Leeds method of preliminary consultation by medical witnesses on both sides of the case as to its status. This suggestion, made in 1910, still stands as one of the unfulfilled, fondest wishes of American psychiatry. In 1904 Stedman reported the use of this method of consultation among the experts in a case tried in Massachusetts, as related by Mercier. Twenty years later, at the trial of Leopold and Loeb.

¹⁰⁶ *Ibid*, LXVII (1910-11), 178, italics mine.

¹⁰⁶ *Ibid*, p 179

the "experts for the defense," Drs. White, Healy, Glueck, and Hamill, prior to making their reports suggested that a consultation with the alienists for the state be held, but State's Attorney Crowe could not see his way clear to accepting this suggestion.

In its report of 1910 the Committee on Medical Expert Testimony cited the laws of Maine, New Hampshire, and Vermont to demonstrate the value of preliminary examinations of criminals in mental hospitals, "under the close and constant observation of trained physicians and nurses," and observed that this procedure "is especially advantageous in notorious capital cases." This procedure, the report stated, "is taking root in Massachusetts under recent enactments"; eleven years later the Briggs Law was passed in that state.

"We are in favor," concludes the report, "of any legislation that will secure a definite standard of qualification for medical men giving expert testimony."

The whole report of the Committee on Medical Expert Testimony reflects a spirit of greater scientific clarity than Sanger Brown's remarks about the influence which he, because of the special peculiarity of the law of Illinois, was permitted to exert on the jury to secure the conviction of the woman tried for arson. Psychiatry very early began to express its suspicion that primitive justice is neither efficacious nor just, and that the scientific and enlightened psychiatrist cannot remain among its adherents.

As far back as 1857 there were a few, though isolated, voices charitable to the criminal in general and to the inebriate in particular. Edward Jarvis, for instance, thought that some "insane transgressors" were punished more than sane convicts. Again I must refer to Isaac Ray, whose project of a law (1850) which he prepared at the request of the Association states that "habitual drunkenness would subject an individual to all liabilities and disabilities of insanity."²⁰⁷ The same project of a law denies that a jury is competent to decide the question of insanity. All these ideas were mature in Ray's mind in 1850, and only gradually matured in the minds of the profession as a whole.

At the turn of the century the growing interest in juvenile delinquency finally culminated in the establishment of juvenile courts. The criminal as well as the delinquent became the subject of careful study. The attitude toward the whole problem of crime changed under the impact of

²⁰⁷ *Ibid.*, VII (1850-51), 92 *et seq.*, and 215-233

the newer knowledge coming from such nonmedical quarters as sociology and anthropology; the medical contribution to this change came in the second decade of the twentieth century, from the trend of psychoanalytic thought which had reached America some ten years before. Another direction in which a definite change occurred was in the various procedural reforms in matters where psychiatric problems were involved.

At the present juncture it is difficult if not impossible to trace in detail the various forces which cooperated in bringing about the changes to which allusion has just been made. It is not less difficult to list the various practical results. Suffice it to say that the first two decades of the twentieth century were stormy in many respects. The economic, social, and cultural shifts produced by the forces of an ever-approaching world conflict, the conflict itself in the form of the first World War and the revolutions which followed it, the increasing consciousness of the value of the individual, the ever-growing awareness of the individual's intimate dependence on the social forces around him—all these factors combined found an expression in our psychiatric growth. In more than one respect psychiatry invaded the social field, and the practical sociologist began to look to psychiatry for some answer to many vexing questions. Under the circumstances it was but natural that psychiatry should "invade" the field of criminology.

The influence of psychiatry began to show itself as early as the eighties of the last century, perhaps even a little sooner. When Sir James Stephen's *History of the Criminal Law of England* appeared in 1883, it bore the earmarks of psychiatric influence. Unlike the jurists of the past, "Mr. Justice Stephen of the Queens Bench" was not trying to recapitulate ancient formulae. While he devoted only eighty pages to insanity in his great treatise, he prepared himself well for this chapter by reading most of the leading English and German psychiatric authorities of his day.

On June 17, 1885 Walter Channing, for the Committee on Bibliography, presented a comprehensive review of Stephen's *History*. Channing pointed out that in Stephen's work there was no longer the old rigidity about the right and wrong test, that the author recognized the irresistible impulse. The book was close to human problems, or at least it was not centered on the purely abstract propositions which considered criminal acts without considering the personality of the criminal involved.

That man's behavior cannot be separated from man himself was poign-

antly felt if not fully expressed. The first articulate expression of this principle was voiced by William A. White, a man with all the external attributes of traditional psychiatry—a superintendent of a mental hospital (St. Elizabeths), a good administrator, and an old and active member of the American Psychiatric Association. White was imbued with the spirit of the times and with the newer trends in psychopathology, sociology, and penology. In his *Insanity and the Criminal Law*, which appeared in 1923, White unmasked the psychological motivations of criminal justice. He demonstrated the aggressive, revengeful motives of the criminal law; he pleaded for psychological determinism, for the careful and profound individualization of each case of crime; he decried the "separation of the act from the actor." White cited criminal cases which he himself had studied in great psychological detail and with profound, humane understanding. He wanted to abolish the hypothetical question and suggested that every future criminal lawyer serve an internship in a prison, in the same manner that a doctor serves in a hospital.

Almost eighty years before White, in 1845, the reviewer of Taylor's *Medical Jurisprudence* had said, "We feel the urgent necessity of assimilating the language of the lawyer and the physician in their investigations and in their decisions. Unless each fully understands and appreciates the other, and in particular in the use of so important a matter as the various forms of insanity, we must hope in vain for improvement."¹⁰⁸

When William A. White spoke before the joint session of the Judicial Section and the Section of Criminal Law and Criminology of the American Bar Association in 1927, the title of his paper was "The Need for Cooperation between the Legal Profession and the Psychiatrist in Dealing with the Crime Problem."¹⁰⁹ It was coöperation in fact rather than understanding of the language only that was stressed. "The psychiatrist in his contact with the legal machinery finds that the methods of procedure are such as to make it well nigh impossible for him to mobilize his knowledge in any useful way for the assistance of the courts in dealing with the individual problems before him." Here again stress is laid on individual problems, and White reiterates his objections to "the law with its emphasis upon the act rather than the actor."

"The question of responsibility carries with it a metaphysical implication and the more one thinks of it the more one feels quite incapable of

¹⁰⁸ *Ibid.*, II (1845-46), 81.

¹⁰⁹ *Ibid.*, LXXXIV (1927-28), 493-505.

answering it." William Healy arrived at this same conclusion in his classic *The Individual Delinquent*, which appeared in 1915.

"The remedies upon which the law seems to repose are hangovers, as it were, of a theological age," insisted White. Crime is subject to social laws, and social laws are natural laws. Newton did not make but found the law of gravity; legislatures should not make but find the law in the same manner. There should be no fear of violating traditions; the institution of juvenile courts was a violation of a tradition. Criminals should be studied and treated, and not merely kept imprisoned. "Our prisons contain great masses of humanity, and within their walls are incarcerated the solutions of most of our most pressing crime problems, if we had but the wisdom to interpret the meanings that are incarcerated in the lives of the prisoners."¹¹⁰

Similar views were expressed by Bernard Glueck, who worked at Sing Sing Prison and who was one of the pioneers of the newer criminology.

The name of Sheldon Glueck stands out in the field of legal thought on this problem. His classic *Mental Disorder and the Criminal Law*, which appeared in 1925, is soundly based on the knowledge modern psychiatry has at its disposal. It contains a detailed analysis of the old legal fallacies and is replete with judicious suggestions for creative reform of the criminal law.

Just as the nineteenth century through its cause célèbre, the Guiteau case, demonstrated the essential characteristics of the old, so did the twenties of the current century—which seem to have been the golden years of awakening in the field of psychiatric criminal jurisprudence—have a cause célèbre revealing the modern trends. This was the case of Leopold and Loeb, the two youngsters under twenty who killed a boy of twelve to experiment and to verify their paranoid, Nietzschean philosophy of the permissibility of a perfect crime. Clarence Darrow was the chief defense counsel; his summation of the case is well worth re-reading, for it is the best and most dramatic exposé of all the evils of expert psychiatric testimony. White, Glueck, and Healy were the chief expert witnesses. Karl Bowman and Harold S. Hulbert made the preliminary study of the two defendants and prepared the preliminary clinical report. The work of the experts in this case was the nearest approach we have to a complete scientific, psychiatric, criminological job.

¹¹⁰ *Ibid.*, p. 501.

The newer trends so ably and so earnestly represented by the expert witnesses in the Leopold-Loeb case, this most telling example of psychopathological criminal symbiosis, are alive in present-day American psychiatry, but thus far they have not materially affected the spirit or the procedure of the criminal law. The judge did sentence Leopold and Loeb to life imprisonment instead of sending them to the gallows; he may have been impressed, as he well might have been, by the weight of psychiatric expert testimony and by Darrow's magnificent, burning, and bitter appeal to scientific psychological and sociological analysis of the criminal and *his* crime, not crime in general. But the judge did find purely legal grounds on which to base his acceptance of the plea for mitigation. The law, some twenty years before the centenary of the Association and still at the present time, has found itself unable to be convinced by the views on crime which many psychiatrists have learned to adopt, although the psychiatrists' knowledge of man's motivations allows them to assert these views with all the power of scientific laws

Some ten years after the Leopold-Loeb case was adjudicated, the Section of Neurology and Psychiatry of the New York Academy of Medicine, jointly with the New York Neurological Society at its regular meeting, discussed "Psychiatry and the Criminal Law." In this discussion the new scientific-humanitarian trends of modern psychiatry stood out sharply, as they had in a discussion in the same Academy some seventy years before, when Dr. Parigot read a paper on "Moral Insanity" and Judge Edmonds¹²¹ carried the banner of progressive psychiatry. In this later meeting, on November 13, 1934, it was Bernard Glueck who represented the advance guard of psychiatry:

The problem [of crime] obviously involves the complete social-economic structure and the tendencies of contemporary American civilization. . . . The only hopeful approach to the problem of criminal conduct lies in the application of a scientific individualized approach which has rehabilitation and reconstruction as its end in place of the traditional impersonal and more or less mechanical procedure that characterizes the legal approach to these problems. . . . It would not seem altogether visionary to think of the future court of criminal law as approaching more closely the characteristics of a clinic in human maladjustment. I believe that one can look forward to a day when these courts will indeed become social clinics for the amelioration and possibly the solution of the problems of adjustment to civilized communal living.

¹²¹ See pp 558-559

They will then be dominated by a spirit of scientific inquiry, using every available facility for the promotion of meliorative and curative ends. These courts will be run by adequately trained people who will be subject to the same kind of professional scrutiny and supervision as is the physician of today.¹¹²

Psychiatry deals with the sources, the nature, the vicissitudes, and the effects of human thought and feeling, and human action and conduct. In order to be at all effective in the performance of this task, the psychiatrist must take into consideration not only the subjective, or internal world of influence that shapes the human being, but also the external world of influence that goes to shape and condition the human personality, namely, those influences which flow from the home, the school, the shop, the playground, the various social institutions which man has created for his guidance, including, of course, the institution of the criminal law. As far as the latter is concerned, I am entirely convinced, after studying many hundreds of criminal careers, that the chances of reformation of a given criminal are in reverse ratio to the amount of contact he has had with the law. It is for this, if no other reason, that the psychiatrist is concerned with the functioning of the law, as indeed he is with every other institution governing man's conduct as a member of society.¹¹³

Glueck despaired of any progress if we submit

. . . to the tyrannies and compulsions of those shibboleths of the law which insist upon a pursuit of values that have no relation whatsoever with the fundamental question of social security. I frankly admit that I have no interest whatsoever in those values which have as their objectives the meeting of the requirements of the rules of the game, called criminal justice. There is only one value which justifies the entire procedure, and that is social security. I believe that social security with the least incidental violence to the individual should be the outstanding aim and purpose of the criminal law, and I do not believe that any good can be achieved by a backward-looking worshipfulness of the traditional precepts and theories of the criminal law.¹¹⁴

It should be noted that this radical change of view with regard to the function of the criminal law, while characteristic of psychiatry, is also to be found in certain quarters of the legal profession—more among the teachers of law, of course, than among those who are engaged in the practice of it. Among these, Professor Sheldon Glueck of Harvard is to be singled out as the most consistent and active proponent of changes in attitudes and procedures. Professor Glueck is the representative of that section of American legal thought which is most avowedly and

¹¹² *J Nerv and Ment Dis*, LXXXI (1935), 192-193

¹¹³ *Ibid*, pp. 210-211.

¹¹⁴ *Ibid*, p. 211.

thoroughly influenced by the recent contributions of psychiatry to the psychology of crime, criminology, and penology. There are of course others who are less openly or less directly but rather definitely influenced by the newer trends.

So much for a general survey of the trends. For details the reader will again have to be referred to the comprehensive work of Sheldon Glueck mentioned above,¹²⁵ just as for the details of procedural reform or changes he will have to be referred to the excellent compilation, *Insanity as a Defense in Criminal Law*, by Henry Weihofen.

Nor is it deemed worth while at present to go beyond mere mention of the development of institutions for the criminal insane. These are administrative, organizational features of the growth of the psychiatric profession and are, strictly speaking, outside the scope of an essay on the legal aspects of psychiatry—as are, perhaps to a less extent, such plans as the “Pennsylvania Plan” for training in penal psychiatry. Mention should be made of the fact that the interest, and the ever broadening of the scope of this interest, in forensic problems led to the organization of a Section on Forensic Psychiatry of the American Psychiatric Association in 1934, with William A. White as its first chairman, and to the founding by Vernon C. Branham of the *Journal of Criminal Psychopathology* (1939).

What is left now to record briefly are certain procedural changes, or rather mileposts in the evolution of forensic psychiatric problems as far as certain practical procedural steps are concerned.

As is known to all who have some interest in forensic psychiatry, only the state of New Hampshire has a law which states that the question of insanity is a question of fact and not of law. This law was established by the decision of Judge Doe in 1866 and reformulated by Judge Ladd in 1871. There is no legal test of responsibility in New Hampshire; the question of sanity is determined by the superintendent of the State Hospital.

The best law thus far evolved by any state is the Briggs Law of Massachusetts, which was adopted in 1921. Winfred Overholser presented an excellent review and appraisal of the Briggs Law at the ninetieth meet-

¹²⁵ *Mental Disorder and the Criminal Law* (Boston, Little, Brown, 1925); see also Glueck's *Crime and Justice* (Boston, Little, Brown, 1936) and *Criminal Careers in Retrospect* (New York, Commonwealth Fund, 1943)

ing of the American Psychiatric Association in 1934, in which he summarized the essential features of the law as follows:

The significant and unusual features of the law are three in number: (1) the examination is conducted by neutral, impartial experts, (2) these experts are selected by a professional department of the administrative branch of government, namely, the Department of Mental Diseases of the Commonwealth; (3) the examination is applicable to *all* defendants falling within certain clearly-defined legal categories, and is not dependent upon the supposed "recognition" of mental disease by the judge, defense attorney, or some other non-psychiatric participant in the proceedings¹¹⁸

It must be observed that this law unfortunately applies only to capital offenders, and that the opinions of psychiatrists are not admissible as evidence.

In 1925 the first report of the new Committee on Legal Aspects of Psychiatry of the American Psychiatric Association was published. The report was submitted by Dr. Karl Menninger as chairman. It marked a true turning point in the history of the problem, and Karl Menninger's name must rightly occupy an honorable place among the pioneers of an important and difficult task. His successors to the chairmanship of the Committee on Legal Aspects of Psychiatry—Kline, L. Vernon Briggs, White, Joseph W. Moore, Overholser, and Paul Schroeder—have continued the contacts with the American Bar Association through a committee of its Section on Criminal Law and Criminology. This committee functioned under the chairmanship of Professor Rollin M. Perkins, with two other members—Louis S. Cohane and Alfred Bettman.

Together these two committees have worked out ways and means for the education of the lawyer in psychiatric problems and for introducing reforms in our legal procedures in relation to mental disorders. Out of this cooperative effort a number of pronouncements have come which certainly presage a new and better day for psychiatric contributions to practical criminology. To use the words of Overholser, it would be folly to believe that all this came as a "bolt from the blue." "Significant steps

¹¹⁸ *Am. J. Insanity*, XCI (1934-35), 585, see too Deutsch, *op. cit.*, pp. 404-406. It is also to Dr. Overholser that we owe the most succinct survey of the history of the cooperation between American psychiatry and the legal profession. "Ten Years of Co-operative Effort," *J. Criminal Law and Criminology*, XXIX (1938), 23-36

in progress result from the fermentation of ideas, and these ideas, in turn, originate in the minds of progressive individuals."¹¹⁷

In 1932 Louis S. Cohane exclaimed: "Let us not by a slavish adherence to the forms of criminal law and procedure which were adopted for and adapted to an age long since past, be behind the times in our methods of handling the modern crime problem and criminals."¹¹⁸ Cohane expressed the general feeling which three years previously, in 1929, took the form of a series of recommendations made by the Committee on Legal Aspects of Psychiatry and accepted by the American Bar Association:

1. That there be available to every criminal and juvenile court a psychiatric service to assist the court in the disposition of offenders.
2. That no criminal be sentenced for any felony in any case in which the judge has any discretion as to sentence until there be filed as a part of the record a psychiatric report.
3. That there be a psychiatric service available to every penal and correctional institution.
4. That there be a psychiatric report on every prisoner convicted of a felony before he is released.
5. That there be established in every state a complete system of administrative transfer and parole, and that there be no decision for or against any parole or any transfer from one institution to another without a psychiatric report.¹¹⁹

From the standpoint of historical value, it is difficult to overestimate the progressive strides thus made, strides in which the legal and psychiatric profession seek not only to talk a common language but also to establish a proper basis for common practice. However, from the standpoint of historical perspective one should not overestimate the originality of the effort or the accomplishment actually attained.

The process involved laborious work along a difficult road. As early as 1907 Sidney Schwab in St. Louis was successful in organizing an "Insane Commission of the St. Louis City Jail." The Commission had no legal status; it was composed merely of "the jail physician and three specialists in mental and nervous diseases."

In 1909 the New York State Bar Association suggested that a panel of physicians be formed as a step toward abolishing certain unattractive

¹¹⁷ Overholser, "Ten Years of Co-operative Effort," p. 23

¹¹⁸ *Ibid.*, p. 27.

¹¹⁹ *Ibid.*, p. 28.

aspects of expert testimony. The New York Psychiatric Association suggested the abolition of the hypothetical question. In 1917 the American Institute of Criminal Law and Criminology, which was established in 1910, suggested legislation on the problem of expert testimony, and in the same year it recommended that joint consultation between the experts of the "opposite sides" be held—a type of consultation which the state's attorney rejected in the Leopold-Loeb case.

Various clinics for psychiatric work preliminary to trial or other legal measures began to be organized. In 1931 the New York City Court of General Sessions established a psychiatric clinic. This was not the first such clinic in the country. The oldest is the psychiatric clinic at the Recorder's Court of the city of Detroit (founded in 1919–1921). The next to be established were the Medical Department of the Supreme Bench in Baltimore (1925) and the Chicago Criminal Court Clinic (1930–1931); in Chicago the Municipal Court Laboratory had been established several years before. Among the newest clinics are that of the Cleveland Court, the Pittsburgh Behavior Clinic, Court Quarter Sessions, and the Medical Division of the Municipal Court of Philadelphia.¹²⁰

These clinics are perhaps the most eloquent and most efficacious expression of the cooperation between the law and psychiatry in which newer and less punitive orientations are gradually being instilled. Yet it should be remembered that these clinics are mere adjuvants to a fundamental criminal law which is not yet reformed. The fundamental change of the law still awaits its day.

In 1922 an associate justice of the Supreme Court of California urged . . . that insanity be no longer treated as a defense to a criminal charge, and that evidence on that subject be excluded from the jury trying a criminal case; that after conviction the defendant upon suggestion of insanity, be examined by a board of alienists with a view to determining whether the defendant should be committed to the state hospital, or prison, or be released under probationary supervision to private hospital or to other custody; that the judge be empowered to make such supervisory orders from time to time upon the advice of competent alienists as may be necessary, and that the state retain jurisdiction over the defendant even after an apparently complete cure for at least as long as the maximum term of imprisonment for the offense, resuming custody of the defendant during that period whenever symptoms of a relapse make further custody desirable for the protection of the public.¹²¹

¹²⁰ I owe to Dr. Lowell S. Selling verification of the above.

¹²¹ Quoted by Weihofen, *op. cit.*, pp. 429–430.

Here we find blended the fundamental psychiatric *curative* idea with the idea of *social security*, which is or ought to be the major goal of the law.

If the various procedural improvements are not accompanied by fundamental changes in our revengeful attitude toward the transgression of the law, they are of course bound to be what might be called negative improvement. But negative improvement should by no means be considered of little value. The history of the so-called Lunacy Commissions in New York are a case in point. In the case of Robert Irwin, who killed three persons in New York City in March, 1937, the Commissioners in Lunacy rendered a report which was a deliberation and exposition of legalistic generalities in the best tradition of 1843, with all the characteristic obscurities and abstractions of this tradition. These Commissioners in Lunacy based their conclusions on hearsay and generalities since the defendant, a paranoid, psychotic individual, refused to be examined by them. In reviewing their report Overholser¹²² pointed out their fallacies, the essential unsoundness of the system of "Commissioners in Lunacy," and the scientific tenuousness and political abuse which this system represented. In 1939 the Desmond Bill, abolishing the Commissions in Lunacy, was passed by the New York State Legislature and soon afterward signed by the Governor. This type of negative improvement is of inestimable value.

History still awaits the positive change of the McNaghten rules into sounder psychological principles. In the meantime, as has been pointed out above when I cited an opinion of Justice Cardozo regarding delusions, the legal mind seeks new ways to achieve a conciliation between its newly acquired enlightenment and its older conceptions which have become statutory or sanctified by common law. Naturally, while the lawyer occasionally succeeds in his efforts as far as logic is concerned, he fails in substance. This is what led William A. White to disagree with Professor Edwin R. Keedy, although the latter was most sympathetic to psychiatry and to White and was responsible for a number of valuable suggestions through various committees of the American Institute of Criminal Law and Criminology. When Keedy suggested that the jury is not called upon to determine whether the criminal is sane or insane but "whether the mental element required by law was present," he expressed the situation with considerable accuracy; but the problem of jury trials to determine

¹²² *Am J Insanity*, XCV (1937-38), pp. 733-736.

abnormal mental states remains unsolved. When Keedy averred that "Responsibility means accountability for one's actions to some superior power, which in this case is the criminal law. . . . According as the law of one sovereignty differs from another so responsibility varies"—the issue of legal responsibility remained unsolved, and an understanding of the psychology of aggression and revenge on the part of the law, so well described by White, became even more obscured.

The fundamental issue raised one hundred years ago was that the law dealt with psychiatric problems by establishing a series of purely intellectual categories. The law always stressed the intellectual defect which had to be demonstrated in every case of alleged insanity. That is why the concept of moral insanity was so vigorously rejected.

One hundred years later we find that American psychiatry for the most part has followed the path outlined by Isaac Ray's keen and vigorous intuition and is still combating the purely intellectual, conceptual thinking of the law. Under different terms and guises, the concept of moral insanity which Isaac Ray so steadfastly propounded is being reasserted by American psychiatry, by its laying stress on the evaluation of the affective, sociological, and biological aspects of the criminal individual. The curative protection of society is taking precedence in the philosophy and practice of psychiatry in relation to the law, rather than the purely formalistic rearrangement of concepts in a set, procedural manner.

Perhaps Isaac Ray was more than justified when he suggested in his project of a new law that the prosecution should be charged with the task of proving the sanity of the accused, instead of throwing the burden of proving insanity on the defense. One is inclined to suspect that such a law as was suggested by Ray would force the legal profession to learn more about psychopathology than it is wont to do about these "afflictive dispensations of Divine Providence," as William H. Stokes called mental disease when he spoke in Baltimore in 1853 on "A Court of Medical Experts in Cases of Insanity."¹²⁸ The purely intellectual approach to mental disease, which would make purely rational functions a test or proof of sanity and criminal responsibility, provokes a reminder which the *Journal's* reviewer gave us some fifty years ago, when he recalled Pope's verse:

Great wit is unto madness near allied,
And thin partitions do their bounds divide.

¹²⁸ *Ibid.*, X (1853-54), 112-122.

And finally, perhaps the fear that the editors of the *Journal of Insanity* had one hundred years ago that the recognition of Ray's views would lead to having to establish "a lunatic asylum in every county" is being dispelled (or justified) by the establishment of court and child guidance clinics. The ultimate abolition of the principle that a jury by a vote may decide whether a man who committed a crime is sane or insane must also be effected, for otherwise there is more truth than persiflage in the reported remark of the English poet Nat Lee,¹²⁴ who was an inmate of Bedlam and who is supposed to have said: "The world and I differed as to my being mad, and I was outvoted."

¹²⁴ *Ibid.*, II (1845-46), 272.

Henry M. Hurd
1898-1899

A. E. McDonald
1903-1904

Geo. C. Rogers
1899-1900

W. W. Burgess
1904-1905

C. B. Burr
1905-1906

P. M. Moore
1900-1901

Charles H. Hill
1906-1907

R. J. Preston
1901-1902

C. P. Bancroft
1907-1908

G. Alder Thomas
1902-1903

A. B. Landrum
Died before taking office

Arthur S. Kilbourne
1908-1909

W. F. Drew

1909-1910

E. A. Tamm

1915-1916

Paul W. Piquette

1910-1911

Charles G. Wagner

1916-1917

Hubert Work

1911-1912

J. V. Anglin

1917-1918

J. T. Searcy

1912-1913

E. C. Southard

1918-1919

Charles W. McDermott

1913-1914

H. C. Eymann

1919-1920

S. E. Smith

1914-1915

Owen Coffey

1920-1921

Albert M. Bennett.

1921-1922

Samuel J. Orton.

1928-1929

H. W. Mitchell.

1922-1923

Wm. H. Bond

1929-1930

Thomas W. Loomis

1923-1924

W. W. Fay Webb

1930-1931

Wm. A. White

1924-1925

W. H. Russell

1931-1932

C. Lloyd Handland

1925-1926

James May

1932-1933

George M. Kline

1926-1927

George H. Kirby

1933-1934

David Meyer

1927-1928

W. F. Wheeler
1934-1935

William C. Sanders
1939-1940

W. F. Wheeler
1935-1936

William C. Sanders
1940-1941

W. F. Wheeler
1936-1937

J. C. Hall
1941-1942

W. F. Wheeler
1937-1938

Arthur Ruggles
1942-1943

W. F. Wheeler
1938-1939

W. A. G. G. G. G.
1943-1944

CLYDE KLUCKHOHN

THE INFLUENCE OF PSYCHIATRY
ON ANTHROPOLOGY IN AMERICA DURING
THE PAST ONE HUNDRED YEARS

A PRESENTATION of this subject matter will be simplified if it is pointed out at the outset that American anthropologists have been influenced almost exclusively by psychoanalytic psychiatry. It may be argued whether this circumstance has resulted, as Allport¹ has suggested, because psychoanalysis "is the most effortless type of psychology to lean upon," or because of genuine convergence upon a series of fundamental assumptions,² or because of an intricate network of historical accidents. But the fact is beyond dispute. A few anthropologists, of course, have had intellectual contacts with nonanalytic psychiatrists; but the name of Dr. Adolf Meyer is the only one which recurs frequently enough in informal conversations within the profession to indicate any influence transcending the purely casual or that which a chance personal relationship happened to bring to an individual anthropologist. Even in the case of Dr. Meyer, one may suspect that most anthropologists of psychiatric orientation have at most a hazy conception of his point of view.

Certainly from the study of anthropological literature one gets an overwhelming impression that it is only psychoanalytic writers who are extensively read by anthropologists in this country. One would be hard-pressed to discover five citations to nonanalytic psychiatrists, with the exception of Rorschach.

This generalization as to the predominance of psychoanalysis in anthropological thought may be both widened and narrowed. It may be widened by calling attention to the fact that anthropologists have obtained much more than psychiatric notions, in any limited sense, from the psychoanalytic movement. Although a few American anthropologists have shown some interest in the problems of perception and of intelligence tests, academic psychology has had a surprising minimum of influence upon anthropology. Almost the only concept of any wide cur-

¹ Gordon W. Allport, *The Use of Personal Documents in Psychological Science* (Social Science Research Council, Bull. 49, New York, 1942), p. 47.

² O. H. Mowrer and C. Kluckhohn, "Dynamic Theory of Personality," in *Personality and the Behavior Disorders* (ed. J. Hunt, New York, The Ronald Press, 1944), pp. 69-75.

rency which has been taken over from academic psychology is that of the sentiment (which came mainly via Radcliffe-Brown and other British anthropologists). The influence of Gestalt psychology upon Benedict and others may also be noted. With these qualifications, it must be said that American anthropology, for good or for ill, has seemed to find only in psychoanalysis the bases for a workable social psychology.

The generalization may be narrowed by noting that we need say little of the older psychiatries which originated in, but diverged from, Freudian psychoanalysis. Jung is talked about by anthropologists fairly occasionally, and one sees references to his work, especially to the personality types, now and then.³ Radin⁴ discussed the implications of Jung's theories for ethnology and predicted that Jung would have a greater influence than any of the scientific group. This prediction has thus far notably failed of justification. Jung's systematic influence in this country in contrast to Great Britain seems to have been restricted to one psychiatrist who used ethnological data and published in anthropological media.⁵ Of Rank there is barely casual mention,⁶ and in the professional literature I have discovered but three incidental references to Adler.⁷ The so-called "Neo-Freudians" (Horney, Kardiner, Fromm, and others) have, as is well known, been highly influential in anthropological circles during the past few years.

The dominant currents in American anthropology prior to, roughly, 1920 were descriptive and historical. Anthropologists were, understandably, obsessed with the necessity of making adequate records of non-literate societies before these had disappeared or been altered beyond recognition by contact with European cultures. To this day, anthropologists as a group are relatively unsophisticated in broad intellectual matters. In large part, this tendency may be traced to a major condition of their intellectual lives: The time which other social scientists may give

³ Margaret Mead, "The Use of Primitive Material in the Study of Personality," *Character and Personality*, III (1934), 11.

⁴ Paul Radin, "History of Ethnological Theories," *Am. Anthropol.*, XXXI (1929), 26-30.

⁵ William Morgan "Navajo Diagnosticians," *Am. Anthropol.* XXXIII (1931), 390-402, "Navajo Dreams," *ibid.*, XXXIV (1932), 390-405; *Human-wolves among the Navaho* (Yale Univ. Publications in Anthropology, No. 11, 1936), pp. 3-43.

⁶ Cf. J. S. Lincoln, *The Dream in Primitive Cultures* (London, The Cresset Press, 1935), p. 12. Alexander Goldenweiser, "Some Contributions of Psychoanalysis to the Interpretation of Social Facts," in *Contemporary Social Theory* (ed. H. Barnes and F. B. Becker, New York, D. Appleton Century, 1940), p. 402.

⁷ Radin, *op. cit.*, p. 26; Edward Sapir, "Personality," in *Encyclopedia of the Social Sciences*, XII (1934), 86, Goldenweiser, *op. cit.*, pp. 401-402.

work in the library the anthropologist must give to field work, to preparation for field trips, to the study of difficult non-Indo-European tongues. Such attention as the earlier American anthropologists gave to strictly theoretical questions was almost entirely confined to diffusion versus independent invention and various other "historical" issues.

These statements are as true as any assertions of comparable breadth can be. Naturally, some writers treated problems in which a psychiatrist could be interested. Thus Brinton has a chapter on "Pathological Variation in the Ethnic Mind," in which he repeats that fallacious and persistent dogma of the folklore of science: "Diseases of nervous and mental exhaustion belong exclusively among nations of advanced culture."⁸ Writers of monographs often, but not always, devoted a page or two to a description of "mental abnormalities" found within the tribe.⁹ But of awareness of psychiatry—in other than the most diffuse sense that there is such a thing as "mental disease"—there is almost no evidence. Indeed, most anthropologists of the period before 1920 seem almost apologetic when they incidentally allude to individual variations. Anthropology as focused upon the standard, the average, the abstracted culture patterns. It is hardly too much to say that the prevalent trend of American anthropology was "anti-psychological."

Gradually there developed a realization that, after all, even culture is manifested in the concrete only by individuals, and that hence it was possible to obtain personal documents. This method of attack seems to have been stimulated by Professor Boas. In 1906 Kroeber published three brief personal narratives of war experience as told by Gros Ventre Indians. In 1913 Radin provided a short Winnebago autobiography, and in 1920 a considerably more substantial one. In 1922 a group of American anthropologists, under the editorship of E. C. Parsons, produced a volume of personal sketches, short autobiographies, and other personalized material. A little later Michelson published the autobiography of a Fox woman.

The importance of such endeavors as a preliminary to an interest in strictly psychiatric questions must not be underestimated. Once the individual is admitted as a legitimate object of anthropological study, the way is opened for collaboration with psychiatrists. On the other hand,

⁸ Daniel G. Brinton, *The Basis of Social Relations* (New York and London, G. P. Putnam's Sons, 1902), p. 118.

⁹ For example, A. L. Kroeber, "The Arapaho," *Bull Am Mus Nat Hist.*, VIII (1902), p. 20.

it must be stressed that these early life histories from nonliterate societies were viewed by anthropologists as strictly ethnological documents. They were regarded as useful leads on hitherto undiscovered cultural items and as source material on the legitimate problem of cultural variation. In no one of them is there a reference to a psychiatric source, nor is there any attempt to interpret or illumine them with psychiatric concepts.

Psychiatrists were much quicker to appreciate the value of anthropological materials than were anthropologists to seize upon psychiatric knowledge. I have heard a distinguished American historian of psychiatry remark that even during the middle portion of the last century psychiatrists were searching for a usable anthropology. In any case, before 1920 European psychiatrists had made considerable use of material from "primitives." Kraepelin¹⁰ and others had begun to construct a comparative psychiatry. Freud, Reik, Rank, and other European psychoanalysts had ransacked the older ethnological literature. In this country at least three psychiatrists had published upon nonliterate groups: Brill on the Eskimo;¹¹ Coriat on the Yaghan Indians of South America;¹² Brown on various groups.¹³

Publications of English anthropologists show that they were seriously affected by psychoanalysis about ten years before their American colleagues. In the published record in this country prior to 1920, I have been able to find only three small evidences of contact. One American ethnologist, Parsons, published a brief note in a psychoanalytic periodical.¹⁴ She indicated some familiarity with psychoanalytic theory but carefully eschewed all interpretation. A casual footnote in another paper first published in 1918 evidences that another American anthropologist, Goldenweiser, had become aware of Freud.¹⁵ In the same year Kroeber published in the *American Anthropologist* a brief review of two books by Jung.¹⁶

¹⁰ E. Kraepelin, "Vergleichende Psychiatrie," *Centralblatt für Nervenheilkunde und Psychiatrie*, XXVII (1904), 433-438

¹¹ "Publokto or Hysteria among Peary's Eskimos," *J. Mental and Nerv. Dis.*, XL (1913), 514-526.

¹² "Psychoneurosis among Primitive Tribes," *J. Abnormal Psychol.*, X (1915-16), 201-208

¹³ Sanger Brown, "The Sex Worship and Symbolism of Primitive Races," *J. Abnormal Psychol.*, X (1915-16), 297-314, 418-432.

¹⁴ E. C. Parsons, "Ceremonial Consummation," *Psychoanalytic Rev.*, II (1915), 358-359

¹⁵ Goldenweiser, *History, Psychology, and Culture* (New York, Knopf, 1933), p. 67.

¹⁶ Review of Jung's *Collected Papers in Analytical Psychology* and *The Psychology of the Unconscious*, in *Am. Anthropol.*, XX (1918), 323-324

In 1920 came the first proof that some of the leaders in American anthropological thought were giving serious consideration to psychoanalysis. Lowie devoted several pages of his *Primitive Society* to a "refutation" of the Freudian explanation of the mother-in-law taboo.¹⁷ Professor Boas had repeatedly insisted upon the importance to anthropology of studies of the individual—even though most of the empirical work done by Boas in cultural anthropology had, like that of his pupils, been preoccupied with descriptive and historical matters. Now, in a general discussion of "The Methods of Ethnology," he stated explicitly his belief that "some of the ideas underlying Freud's psychoanalytic studies may be fruitfully applied to ethnological problems." However, he ended his article with some cautious remarks which are representative of the difficulties felt by even the more sympathetic anthropologists from that day to this:

The theologians who interpreted the Bible on the basis of religious symbolism were no less certain of the correctness of their views, than the psychoanalysts are of their interpretations of thought and conduct based on sexual symbolism. The results of a symbolic interpretation depend primarily upon the subjective attitude of the investigator who arranges phenomena according to his leading concept. In order to prove the applicability of the symbolism of psychoanalysis, it would be necessary to show that a symbolic interpretation from other entirely different points of view would not be equally plausible, and that explanations that leave out symbolic significance or reduce it to a minimum, would not be adequate.

While, therefore, we may welcome the application of every advance in the method of psychological investigation, we cannot accept as an advance in ethnological method the crude transfer of a novel, one-sided method of psychological investigation of individual to social phenomena the origin of which can be shown to be historically determined and to be subject to influences that are not at all comparable to those that control the psychology of the individual.¹⁸

In this same year (1920) there appeared the first article in an American anthropological publication to be devoted entirely to psychiatric questions.¹⁹ In this consideration of *Totem and Taboo* Professor Kroeber rejected Freud's conclusions but praised many of his concepts and insights: "But, with all the essential failure of its finally avowed purpose,

¹⁷ New York, Boni & Liveright, 1920, pp. 91-94.

¹⁸ *Am. Anthropol.*, XXII (1920), 321.

¹⁹ A. L. Kroeber, "Totem and Taboo: an Ethnologic Psychoanalysis," *Am. Anthropol.*, XX (1920), 48-55.

the book is an important and valuable contribution" (p. 63); "the book . . . thus is one that no ethnologist can afford to neglect" (p. 55). Herein Kroeber appeared much wiser than many American anthropologists, down to the present. The fact that Freud, in this and other works, relied mainly upon anthropologists of "the English evolutionary school" was a major stumbling block to professional acceptance in America. Here it was felt that these data (themselves dubious because culled without too much discrimination from the accounts of travelers and missionaries) had been processed into spurious generalizations by invalid methods. The conventional American anthropologist dismissed Freud's anthropology as bad and his conclusions as worthless. With regrettable but familiar illogic, psychoanalytic method and theory were therewith rejected.

To some degree, this may be merely the rationalization covering a deeper psychological factor. Perhaps the tendency to ignore or to be resistive to psychiatry springs from a temperamental selectivity of the anthropological profession. Anthropology as it was conceived (and still is, by many) in this country was a refuge for those who were impelled by inner, largely unconscious, needs to escape from the personal or "to crawl back into the womb of the cultural past" Sapir was keenly aware of the temperamental antithesis:

What is the genesis of our duality of interest in the facts of behavior? Why is it necessary to discover the contrast, real or fictitious, between culture and personality, or, to speak more accurately, between a segment of behavior seen as cultural pattern and a segment of behavior interpreted as having a person-defining value? Why cannot our interest in behavior maintain the undifferentiated character which it possessed in early childhood? The answer, presumably, is that each type of interest is necessary for the psychic preservation of the individual in an environment which experience makes increasingly complex and unassimilable on its own simple terms. The interests denoted by the terms culture and personality are necessary for intelligent and helpful growth because each is based on a distinctive kind of imaginative participation by the observer in the life around him. The observer may dramatize such behavior as he takes note of in terms of a set of values, a conscience which is beyond self and to which he must conform, actually or imaginatively, if he is to preserve his place in the world of authority or impersonal social necessity. Or, on the other hand, he may feel the behavior as self-expressive, as defining the reality of individual consciousness against the mass of environing determinants. Observations coming within the framework of the former of these two kinds of participation constitute our knowledge of culture. Those which

come within the framework of the latter constitute our knowledge of personality. One is as subjective or objective as the other, for both are essentially modes of projection of personal experience into the analysis of social phenomena. Culture may be psychoanalytically reinterpreted as the supposedly impersonal aspect of those values and definitions which come to the child with the irresistible authority of the father, mother, or other individuals of their class. The child does not feel itself to be contributing to culture through his personal interaction but is the passive recipient of values which lie completely beyond his control and which have a necessity and excellence that he dare not question. We may therefore venture to surmise that one's earliest configurations of experience have more of the character of what is later to be rationalized as culture than of what the psychologist is likely to abstract as personality. We have all had the disillusioning experience of revising our father and mother images down from the institutional plane to the purely personal one. The discovery of the world of personality is apparently dependent upon the ability of the individual to become aware of and to attach value to his resistance to authority. It could probably be shown that naturally conservative people find it difficult to take personality valuations seriously, while temperamental radicals tend to be impatient with purely cultural analysis of human behavior.²⁰

It is an induction from my own observation that a majority of American anthropologists, at least of those of the older generation, seem to be made uncomfortable by discussion of topics which relate to persons or individuals rather than to cultural forms. This discomfort is manifested by nuances of behavior as well as by a hasty displacement of responsibility ("Yes, I suppose I have to admit that those questions are important but they are none of our business as anthropologists. Let the psychiatrists and psychologists worry about them."), or by an impatient deathblow with threadbare professional clichés ("You know perfectly well that Kroeber and Opler showed that Freud was absurd and that Malinowski proved there was no such thing as the oedipus complex in the Trobriand Islands.").

This interpretation may be questioned, but there can be no doubt that until roughly fifteen years ago one could gorge oneself upon anthropological literature without ever coming face to face with the type of problem which is all important in psychiatric thinking. There were, to be sure, temporary and occasional exceptions, but they deviated from the main currents. For example, Goldenweiser in his *Early Civilization*²¹

²⁰ Edward Sapir, "The Emergence of the Concept of Personality in a Study of Cultures," *J. Soc. Psychol.*, V (1934), 408-415.

²¹ New York, Knopf, 1922.

referred to Freud many times and gave a number of pages to a systematic exposition of psychoanalytic theory. But much more representative of the general trend is the astonishing fact that in 1924 Lowie published a general treatise on primitive religion in which he did not so much as mention Freud, psychoanalysis, or psychiatry.

Of the acknowledged leaders of the profession only Boas and Kroeber uncompromisingly recognized the significance of psychological issues in anthropological research. Boas was constantly stressing "man's mental life," "psychic attitudes," and "subjective worlds"²² in his publications and seems consistently to have adhered to this point of view in his teaching. We find Kroeber making this critical stricture upon Lowie's *Primitive Society*: "There is scarcely even anything that psychology, which underlies anthropology, can take hold of and utilize."²³ Kroeber made other similar comments from time to time, yet neither Kroeber nor Boas ever followed psychological lines in his own researches. Boas did stimulate some of his students to do such research—Benedict, Mead, and others; presumably he also influenced Sapir somewhat in this direction. Kroeber's case is curious. He reviewed Jung's *Analytical Psychology*²⁴ and has published (besides the two discussions of *Totem and Taboo* in 1920 and 1939) two incidental papers dealing with the contribution of anthropology to psychiatry.²⁵ Although I am told that he has recently engaged in collaborative research with E. Homburger Erikson, one may search in vain throughout the enormous bulk of his published ethnographic contributions for any application of psychiatric concepts. Of all his many and distinguished students, only Du Bois, Devereux, and Loeb have shown any psychiatric interests, and in each of these cases there is reason to believe that other influences were operative, and that those anthropologists moved toward psychiatry in spite of Kroeber rather than because of him. The question can fairly be put: Was Kroeber's relentless pursuit of "objective" and "historical" enquiries and his avoidance of research into the genesis and functioning of personalities (to which he would unquestionably have brought tremendous and unusual talents) based

²² Cf. Ruth F. Benedict, "Franz Boas as an Ethnologist," *Franz Boas, 1858-1942* (Memoir 61 of the Am. Anthropol. Assn., 1943), pp. 27-38.

²³ *Am. Anthropol.*, XXII (1920), 380.

²⁴ *Am. Anthropol.*, XX (1918), 323-324.

²⁵ "Cultural Anthropology," Chap. XIX in *The Problem of Mental Disorder* (ed. Bentley, New York, McGraw Hill, 1934); "Psychosis or Social Sanction," *Character and Personality*, VIII (1940), 204-215.

upon deep-seated, unconscious factors,²⁶ or was it primarily the submission to an occupational psychosis of his profession?

In the period between 1928 and 1939 the growing rapprochement between anthropology and psychiatry is reflected in the greatly increased number of personal documents and other materials on personality which anthropologists published.²⁷ This trend is paralleled by more frequent, though often grudging, allusions in theoretical statements. The papers by Lowie²⁸ and Wissler²⁹ in which the whole subject of anthropology's relation to psychology was treated without a single allusion to psychoanalysis could hardly have appeared after 1928. A more general awareness of psychoanalysis on the part of anthropologists in this country must be connected with the publications in England by Rivers and Malinowski of extended applications of psychoanalytic concepts to ethnological data.

The new directions seem to have been instigated (and later intensified through teaching and publication) primarily by three persons: Ruth Benedict, Margaret Mead, and Edward Sapir. Although these three tended always to rephrase psychiatric insights in cultural terms, and although others (such as Hallowell and the Oplers) have made more sustained and more direct applications of psychiatric concepts to their own empirical data, still the fundamental theoretical groundwork must be credited to Benedict, Mead, and Sapir.

In 1928 Ruth Benedict, pupil and colleague of Boas, published "Psychological Types in the Cultures of the Southwest."³⁰ This was followed in 1932 by her "Configurations of Culture in North America."³¹ In neither of these papers is there explicit reference to psychiatric sources. The stated acknowledgments are to the Gestalt psychologists and to philosophers of history, notably Dilthey. But every page is colored by an attitude which can only be described as "psychiatric," and which must be traced eventually from the influence of psychiatry. Mead has cogently summarized their essence: "In these first papers Dr. Benedict advanced

²⁶ Cf. Goldenweiser, "Recent Trends in American Anthropology," *Am. Anthropol.*, XLIII (1941), 151-163.

²⁷ For a fairly complete bibliography see John Gillin, "Personality in Pre-literate Societies," *Am. Soc. Rev.*, V (1940), 371-380.

²⁸ "Psychology and Sociology," *Am. J. Soc.*, XXI (1915), 217-230.

²⁹ "Opportunities for Coordination in Anthropological and Psychological Research," *Am. Anthropol.*, XXII (1920), 1-12.

³⁰ Am. Congress of Americanists, *Proceedings*, XXIII (1928), 572-581.

³¹ *Am. Anthropol.*, XXXIV (1932), 1-27.

the hypotheses that cultures and the use which they make of the traditional matter which was the stock of a widespread area could be interpreted as we interpret the choices of an individual personality."⁸³ In a later paper of Benedict's there is manifest attention to psychiatry, but mainly from the angle of anthropology's contribution to it⁸⁴ rather than the reverse. The following lines give perhaps the conceptual nucleus of this paper:

The categories of borderline behavior which we derive from the study of the neuroses and psychoses of our civilization are categories of prevailing local types of instability. They give much information about the stresses and strains of Western civilization, but no final picture of inevitable human behavior. . . . When data are available in psychiatry, this minimum will be probably quite unlike our culturally conditioned, highly elaborated psychoses such as those that are described, for instance, under the terms of schizophrenia and manic-depressive.⁸⁵

In Benedict's *Patterns of Culture*,⁸⁶ the approach is primarily cultural: a restatement and a testing, on the materials from three tribes, of her basic analogy "between the variations in human personality and the variations between cultures." There is, however, systematic treatment of the problems of the individual deviant. She again shows how the idiosyncratic component⁸⁷ of some personalities can find cultural expectations so ineluctably incongenial as to prevent these individuals from fitting acceptably into the patterns, and even drive them to mental illness. A later article⁸⁷ develops another variation upon this same theme of the connection between cultural patterns and individual personality development. It is argued that discontinuities in cultural conditioning, rather than "physiological necessity," are often responsible for maladjustments and personality upheavals. Once again, even though implicitly pointing the way to new types of anthropological research, Benedict is mainly concerned with indicating the relevance of anthropological materials to the psychiatrist:

The anthropologist's role is not to question the facts of nature, but to insist upon the interposition of a middle term between "nature" and "human be-

⁸³ Mead, *op. cit.*, *Character and Personality*, III (1934), 9

⁸⁴ For a psychiatric reply, see H. J. Wegrocki, *J. Abnormal and Soc. Psychol.*, XXXIV (1939), 166-178, and for a further development, see Schilder, *J. Soc. Psychol.*, XV (1942), 3-21.

⁸⁵ Benedict, "Anthropology and the Abnormal," *J. Gen. Psychol.*, X (1934), 79

⁸⁶ Boston and New York, Houghton Mifflin, 1934

⁸⁷ C. Kluckhohn and O. H. Mowrer, "Culture and Personality," *Am. Anthropol.*, XLVI (Jan., 1944).

havior"; his role is to analyze that term, to document man-made doctorings of nature and to insist that these doctorings should not be read off in any one culture as nature itself. Although it is a fact of nature that the child becomes a man, the way in which this transition is effected varies from one society to another, and no one of these particular bridges should be regarded as the "natural" path to maturity.³⁸

The conceptions set forth in the lines just quoted from Benedict constitute a clear statement of the central thread which runs through at least the earlier writings of Margaret Mead. Mead was a pupil of Benedict (and of Boas). Her *Coming of Age in Samoa*³⁹ is a report on the first major piece of empirical research by an American anthropologist to be organized along psychiatric lines. Although she was avowedly testing the hypotheses on adolescence set forth by the psychologist G. Stanley Hall, still much of her approach is patently influenced by psychoanalysis. Boas refers to psychoanalysis in his introduction to the book, and Mead's own interest and knowledge are reflected in a paper published two years later.⁴⁰ Her subsequent researches, best known through the popular publications *Growing up in New Guinea*⁴¹ and *Sex and Temperament in Three Primitive Societies*,⁴² similarly had orientations which converged with the psychiatric. During her first three field expeditions Mead's method was that of the crucial experiment. She focused her efforts upon obtaining evidence which might confirm or disprove some very general hypothesis. She has herself⁴³ indicated this succession of focal questions very clearly:

- 1925: How flexible is human nature? How much can we learn about its limits and its potentialities from studies of societies so very different from, so conveniently simpler than, our own?
- 1930: Is human nature elastic as well as flexible? Will it tend to return to the form that was impressed upon it in earliest years?
- 1935: In judging human nature may human societies make assumptions which their educational systems are unable to carry out?

The asking of these questions is patently contingent upon some cross-fertilization between anthropology and psychiatry. Not only was Mead's

³⁸ *Ibid.*, p. 161.

³⁹ New York, William Morrow, 1928.

⁴⁰ "An Ethnologist's Footnote to 'Totem and Taboo,'" *Psychoanalytic Rev.*, XVII (1930), 297-304.

⁴¹ New York, William Morrow, 1930.

⁴² New York, William Morrow, 1935.

⁴³ *From the South Seas* (New York, William Morrow, 1939), pp. ix-xxxi.

material organized in a fashion which appealed to psychiatrists, but she wrote in an idiom which they found intelligible. Besides the books which have been cited and a number of monographs addressed primarily to an anthropological audience, her work is embodied in an extensive series of papers—many of them on subjects of great psychiatric interest.⁴⁴ It is hardly surprising that Mead is possibly the best-known anthropologist in psychiatric circles. For many years her work has been discussed in the journals of the psychiatric profession, and these discussions have resulted in secondary stimulations to anthropology.⁴⁵

In one of her more recent papers⁴⁶ Mead acknowledges more explicitly than she was earlier wont to do the psychiatric sources which had influenced her. We learn that the work of Abraham, Spitz, and Róheim on "oral" and "anal" characters proved suggestive to her for her field work and for theoretical analysis. Homburger Erikson's system of dealing with zones in relation to character formation is likewise mentioned.⁴⁷ The concept of plot in culture, which seems to have formed the focal point of Mead's most recent field work in Bali, is attributed to Róheim.⁴⁸ The extent to which Mead's point of view remains incompatible with pre-suppositions which would doubtless be shared by most psychiatrists is indicated by a recent controversy with Dr. Alexander.⁴⁹

If Boas is always somehow in the background of the influence of psychiatry upon anthropology, the third of the three persons most influential in laying a fundamental theoretical groundwork for a rapprochement between the two sciences—Sapir—is forever in the foreground. Psychiatry, for Benedict, is merely ancillary to a number of other extra-anthropological approaches; but psychiatry is central in Sapir's theoretical contribution. Mead is probably better known to psychiatrists because she has

⁴⁴ For a list of her earlier papers which are psychiatrically oriented, see Mead, *op. cit.*, *Character and Personality*, III (1934), 10, note 11, for more recent ones, see the Mead bibliography in Bateson and Mead, *Balinese Character* (New York Academy of Sciences, Special Publications Vol. II, 1942)

⁴⁵ See, for example, R. A. Spitz, "Frühkindliches Erleben und Erwachsenen Kultur bei den Primitiven," *Imago*, XXI (1935), 367-387

⁴⁶ "The Mountain Arapesh. II Supernaturalism," *Anthrop. Papers of the Am Mus Nat Hist*, XXXVII (1940), 330-331.

⁴⁷ Cf. also Mead, "Educative Effects of Social Environment as Disclosed by Studies of Primitive Societies," *Environment and Education*, Supplementary Monographs, No. 54 (Chicago, Univ. of Chicago Press, 1942).

⁴⁸ Mead, "Researches in Bali," *N Y Acad Sci, Transactions*, Ser. 2, II, 1-8

⁴⁹ Mead, "Educative Effects of Social Environment as Disclosed by Studies of Primitive Societies," *Environment and Education*, pp. 48-61, Franz Alexander, "Educative Influence of Personality Factors in the Environment," *ibid*, pp. 29-47

published more and provided a greater abundance of field data which appealed to them. Yet it was Sapir who made possible some real fusion between the two disciplines. Benedict and Mead were importantly influenced by psychiatry as to the topics they chose to study, and they were able to show the utility to psychiatry of the raw materials provided by anthropological field work. Only Sapir, however, supplied the necessary corrections to anthropological theory which were demanded by psychiatric knowledge. To him, more than to any other single person, must be traced the growth of psychiatric thinking in anthropology. His conceptual refinements made possible something more than an interchange of facts and ideas. He perceived a certain flatness, a certain unrealism, in the current conceptual scheme of American anthropology, when he checked this scheme against what psychiatry had learned. The tough insights which Sapir drew from psychiatry not only forced a basic reconstruction of anthropological postulates but led to new types of specifically pointed field work. The subtle, tantalizing leads he threw out shaped the basic conceptualizations not only of his immediate pupils and associates (such as Opler, Mekeel, and Dollard) but of many other workers who had no formal relationship to him (Linton, Hallowell, and many others).⁵⁰ Sapir had no formal psychiatric training, so far as I am aware, and was not himself analyzed. But he had intimate personal relationships with a number of psychiatrists, notably Dr. Harry Stack Sullivan. Sapir's psychiatric outlook was discriminating, eclectic, generalized. While deeply swayed by psychoanalysis, he was highly critical of psychoanalytic theory in many respects.⁵¹ Himself exquisitely sensitive to the nuances of personal behavior and a consummate master of the English language, he was able to translate psychiatric conceptions into terms which struck home to even the least imaginative ethnologists.

The preliminary formulation of the fusion which Sapir was able to make is best seen in his brilliant and much neglected "The Unconscious Patterning of Behavior in Society,"⁵² although this essay contains no citations to psychiatric literature and indeed no overt references to psychia-

⁵⁰ How much of the parallelism in the writings of Benedict, Mead, and Sapir is pure convergence and how much represents the influence of Sapir upon Benedict and Mead is a difficult question. I agree with Goldenweiser ("Leading Contributions of Anthropology to Social Theory," in *Contemporary Social Theory*, p. 489) that a careful reading of *Patterns of Culture* "can leave no doubt that on several occasions Benedict found inspiration in the writings of the late Edward Sapir."

⁵¹ "Cultural Anthropology and Psychiatry," *J. Abnormal and Soc. Psychol.*, XXVII (1932), 234-235

try. The essentials of Sapir's contribution and the primary sources of that portion of his influence which did not spring from direct personal contact are to be found in two brief papers.⁵³ It is doubtful that so small a number of pages has ever had such momentous consequences for anthropology.

What, precisely, are the critical issues which anthropological theory had ignored or evaded and which Sapir compelled anthropologists to face? Digests or paraphrases of Sapir are always notably unsatisfactory. Perhaps a series of quotations, even though the intervening passages are not given, will be most nearly adequate: *

But all these [anthropological] approaches agree in thinking of the individual as a more or less passive carrier of tradition or, to speak more dynamically, as the infinitely variable actualizer of ideas and modes of behavior which are implicit in the structure and traditions of a given society. It is what all the individuals of a society have in common which is supposed to constitute the true subject matter of cultural anthropology and sociology. If the testimony of an individual is set down as such, as often happens in our anthropological monographs, it is not because of an interest in the individual himself as a matured and single organization of ideas but in his assumed typicality for the community as a whole . . . He [the anthropologist] always hopes that the individual informant is near enough to the understandings and intentions of his society to report them duly, thereby implicitly eliminating himself as a factor in the method of research. . . . Our ethnological monographs present a kaleidoscopic picture of varying degrees of generality, often within the covers of a single volume.⁵⁴

There is reason, then, to think that while cultural anthropology and psychiatry have distinct problems to begin with, they must, at some point, join hands in a highly significant way. That culture is a superorganic, impersonal whole is a useful enough methodological principle to begin with but becomes a serious deterrent in the long run to the more dynamic study of the genesis and development of cultural patterns because these cannot be realistically disconnected from those organizations of ideas and feelings which constitute the individual. . . . We are not, therefore, to begin with a simple contrast between social patterns and individual behavior, whether normal or abnormal, but we are, rather, to ask what is the meaning of culture in terms of individual behavior and whether the individual can, in a sense, be looked upon as the effec-

⁵³ In *The Unconscious: a Symposium* (New York, Knopf, 1929), pp 114-142. A still earlier paper, "Culture, Genuine and Spurious," *Am. J. Soc.*, XXIX (1924), 401-430, should probably also be cited in this connection.

⁵³ "Cultural Anthropology and Psychiatry," and "The Emergence of the Concept of Personality in a Study of Cultures," *J. Soc. Psychol.*, V (1934), 408-415.

⁵⁴ "Cultural Anthropology and Psychiatry," pp 229-230.

tive carrier of the culture of his group. As we follow tangible problems of behavior rather than the selected problems set by recognized disciplines, we discover the field of social psychology, which is not a whit more social than it is individual and which is, or should be, the mother science from which stem both the abstracted impersonal problems as phrased by the cultural anthropologist and the almost impertinently realistic explorations into behavior which are the province of the psychiatrist.⁵⁵

The so-called culture of a group of human beings, as it is ordinarily treated by the cultural anthropologist, is essentially a systematic list of all the socially inherited patterns of behavior which may be illustrated in the actual behavior of all or most of the individuals of the group. The true locus, however, of these processes which, when abstracted into a totality, constitute culture is not in a theoretical community of human beings known as society; for the term "society" is itself a cultural construct which is employed by individuals who stand in significant relations to each other in order to help them in the interpretation of certain aspects of their behavior. The true locus of culture is in the interactions of specific individuals and, on the subjective side, in the world of meanings which each one of these individuals may unconsciously abstract for himself from his participation in these interactions . . . Such differences of culture never seem as significant as they really are, partly because in the workaday world of experience they are not often given the opportunity to emerge into sharp consciousness, partly because the economy of interpersonal relations and the friendly ambiguities of language conspire to reinterpret for each individual all behavior which he has under observation in terms of those meanings which are relevant to his own life. The concept of culture, as it is handled by the cultural anthropologist, is necessarily something of a statistical fiction and it is easy to see that the social psychologist and the psychiatrist must eventually induce him to reconsider his terms.⁵⁶

Culture, as it is ordinarily constructed by the anthropologist, is a more or less mechanical sum of the more striking or picturesque generalized patterns of behavior which he has either abstracted for himself out of the sum total of his observations or has had abstracted for him by his informants in verbal communication. Such a "culture," because generally constructed of unfamiliar terms, has an almost unavoidable picturesqueness about it, which suggests a vitality which it does not, as a matter of scrupulous psychological fact, embody. The cultures so carefully described in our ethnological and sociological monographs are not, and cannot be, the truly objective entities they claim to be. No matter how accurate their individual itemization, their integrations into suggested structures are uniformly fallacious and unreal. This cannot be helped so long as we confine ourselves to the procedures recognized as sound

⁵⁵ *Ibid.*, p. 233

⁵⁶ *Ibid.*, pp. 235-237.

by orthodox ethnology. If we make the test of imputing the contents of an ethnological monograph to a known individual in the community which it describes, we would inevitably be led to discover that, while every single statement in it may, in the favorable case, be recognized as holding true in some sense, the complex of patterns as described cannot, without considerable absurdity, be interpreted as a significant configuration of experience, both actual and potential, in the life of the person appealed to. Cultures, as ordinarily dealt with, are merely abstracted configurations of idea and action patterns, which have endlessly different meanings for the various individuals in the group and which, if they are to build up into any kind of significant psychic structure, whether for the individual or the small group or the larger group, must be set in relation to each other in a complex configuration of evaluations, inclusive and exclusive implications, priorities, and potentialities of realization which cannot be discovered from an enquiry into the described patterns.⁵⁷

... the tight, "objectified" culture loosens up at once and is eventually seen to be a convenient fiction of thought. . . . Many problems which are now in the forefront of investigation sink into a secondary position and patterns of behavior which seem so obvious or universal as not to be worthy of the distinctive attention of the ethnologist leap into a new and unexpected importance. The ethnologist may some day have to face the uncomfortable predicament of inquiring into such humble facts as whether the father is in the habit of acting as indulgent guide or as disciplinarian to his son and regarding the problem of the child's membership inside or outside of his father's clan as a relatively subsidiary question. In short, the application of the personality point of view tends to minimize the bizarre or exotic in alien cultures and to reveal to us more and more clearly the broad human base on which all culture has developed. The profound commonplace that all culture starts from the needs of a common humanity is, believed by all anthropologists, but it is not demonstrated by their writings.⁵⁸

Two of Sapir's later papers⁵⁹ add little that is new conceptually and are remarkable chiefly for some unforgettably felicitous phrases, such as:

... the pages of Freud, with their haunting imagery of society as censor and of culture as a beautiful extortion from the sinister depths of desire. . . .⁶⁰

In an atmosphere of mollified contrasts one may hope to escape the policemen of rival conceptual headquarters.⁶¹

⁵⁷ "The Emergence of the Concept of Personality in a Study of Cultures," *J Soc Psychol*, XXIX (1934), 408-415

⁵⁸ *Ibid*, p. 413

⁵⁹ "The Contribution of Psychiatry to an Understanding of Behavior in Society," *Am J Soc*, XXIX (1937), 862-871, "Anthropology and the Psychiatrist," *Psychiatry*, I (1938), 7-13

⁶⁰ "The Contribution of Psychiatry to an Understanding of Behavior in Society," pp. 862-863.

⁶¹ *Ibid*, p. 863

One of these papers also contains a warning (presumably addressed to anthropologists tending to move in the Benedict-Mead direction):

It is these actual relationships that matter, not society. This simple and intuitively necessary viewpoint of the psychiatrist is shared, of course, by the man in the street. He cannot be dislodged from it by any amount of social scientific sophistication. It is to be hoped that no psychiatrist will ever surrender this naive and powerful view of the reality of personality to a system of secondary concepts about people and their relations to each other which flow from an analysis of social forms. . . . Certain recent attempts, in part brilliant and stimulating, to impose upon the actual psychologies of actual people, in continuous and tangible relations to each other, a generalized psychology based on the real or supposed psychological implications of cultural forms, show clearly what confusions in our thinking are likely to result when social science turns psychiatric without, in the process, allowing its own historically determined concepts to dissolve in those larger ones which have meaning for psychology and psychiatry.⁸²

Another important figure, Géza Róheim, was trained as a psychoanalyst, but he has done anthropological field work of no little interest and importance and must be regarded as also, in some sense, an anthropologist. He has been a worker of prodigious industry and has published prolifically upon anthropological subjects. Róheim's position is a curious one. To many, perhaps to most, American anthropologists his writings are both violently irritating and simply opaque. A passage like the following, for example, is enough to make the hair of even mildly conservative anthropologists stand on end.

This is the origin of the world beyond the grave. The soul enters heaven as the sperm enters the ovum, and for the same reason. The idea of the loss of the semen or of death would not be bearable without this consolation. There are certain individuals in savage society in whom this castration complex is particularly strong and who manage to get rid of it by castrating others instead of being castrated themselves. These are the wizards, the ancestors of savage medicine-men. It is because coitus is a sort of self-castration that the savage needs a castrator, and projects the image of the castrator into space. The black magician is the man who consents to play the part.⁸³

⁸² *Ibid.*, p. 867.

⁸³ *Animism, Magic, and the Divine King* (London, Knopf, 1930), p. 381.

A very partial list of Róheim's anthropological writings includes: "Ethnology and Folk-Psychology," *Int J Psycho-analysis*, III (1922), 189-222, *Australian Totemism* (London, Allen and Unwin, 1925), "Psychoanalysis of Primitive Cultural Types," *Int J Psycho-analysis*, XIII (1932), 6-22, "Women and Their Life in Central America," *J. Royal Anthropol Inst.*, LXIII (1933), 207-265, *The Riddle of the Sphinx* (London, Hogarth, 1934); "The Study of Character Development and the Ontogenetic Theory of Culture," in *Essays Presented to C. G. Seligman*

Discourse of this sort is both cryptic and repugnant to the modal anthropological reader. Nevertheless there is evidence that those few anthropologists who have closely studied Róheim, and especially his more recent writings, have gained a great deal. One passage in Mead's review of *The Riddle of the Sphinx* may stand as a representative reaction of those anthropologists who really know Róheim:

Dr. Roheim presents an argument bewildering in its tangle of unresolved complexities, elisions, and condensations. After a short introduction posing the problem of the origin of culture, he presents a long description of Australian aboriginal ceremonialism which is practically unintelligible in the terms in which he describes it here. If his previous publications on Australia have been read with great care, and if the reader possesses a good working knowledge of Freudian theory, and a detailed knowledge of the ethnology of Central Australian tribes drawn from other more formal sources, this section becomes relatively intelligible and also very stimulating.⁶⁴

In the period between 1928 and 1939 the published record indicates that the work of at least seven other American anthropologists had received major influences from psychiatry: Ernest and Pearl Beaglehole,⁶⁵ Cora Du Bois, John Dollard, A. I. Hallowell, Scudder Mekeel, and M. E. Opler. Four of these can be dealt with very briefly. The papers of the Beagleholes of special interest to us which have thus far appeared are relatively slight but, like the contributions of Hallowell and Opler, they have the great merit of being direct applications to personally gathered empirical data.⁶⁶ Whether Dollard is an "anthropologist" or a "sociolo-

(ed. Evans-Pritchard *et al*, London, Kegan Paul, 1934), "The Nescience of the Aranda," *Brit. J. Med. Psychology*, VII (1938), 343-360, "Racial Differences in the Neurosis and Psychosis," *Psychiatry*, II (1939), 375-390; "Dreams of a Somali Prostitute," *J. Criminal Psychopathol*, II (1940), 162-170; "Society and the Individual," *Psychoanalytic Q*, IX (1940), 526-545, "Myth and Folk-Tale," *Am. Imago*, II (1941), 266-279, "Play Analysis with Normanby Island Children," *Am. J. Orthopsychiatry*, XI (1941), 524-529, "The Psycho-analytic Interpretation of Culture," *Int. J. Psycho-analysis*, XXII (1941), 1-23, "The Origin and Function of Culture," *Psychoanalytic Rev.*, XXIX (1942), 131-164

⁶⁴ *Character and Personality*, IV (1935), 85

⁶⁵ In this and other cases I have interpreted "American anthropologist" rather liberally. This is a typical example. The Beagleholes are not American by nationality, but they studied in this country, published in American media, and were in sustained face-to-face contact with large numbers of American anthropologists

⁶⁶ See Ernest and Pearl Beaglehole, "Personality Development in Pukapukan Children," in *Language, Culture and Personality* (ed. Spier, Hallowell, and Newman, Menasha, Wis., Sapir Memorial Publication Fund, 1941), Ernest Beaglehole, "Emotional Release in a Polynesian Community," *J. Abnormal and Soc. Psychol*, XXXII (1937), 319-328, Ernest Beaglehole, "A Note on Cultural Compensation," *J. Abnormal and Soc. Psychol*, XXXIII (1938), 121-123.

gist" is an academic question; certainly his influence on anthropologists has been very considerable. Mekeel's publications thus far⁶⁷ have been of an exclusively programmatic order.

Du Bois worked with psychiatrists at the Harvard Psychological Clinic. She published what anthropologists regard as an eminently sound critique of the use of ethnological data by psychoanalysts⁶⁸ and a most helpful digest of some of the aids which psychiatry (and psychology) can offer to the techniques of field work.⁶⁹ "Some Anthropological Perspectives on Psychoanalysis" is something more than a sane synthesis of the criticisms which anthropologists had made of the use of their data by psychoanalysts, it is equally a theoretical essay of unusual insight, posing new problems for anthropological research and rephrasing more sharply some which had been previously presented. For instance:

Are we to assume that the psychological change preceded and induced the cultural change? Or is it necessary to assume the priority of one or the other? If we assume the priority of cultural change, then psychological interpretations of culture are purely descriptive and not explanatory. If we assume the priority of psychological changes, we are faced with the problem of accounting for their origin.⁷⁰

Are psychoses merely culturally defined and simply cultural judgments? In other words, how far are psychoses problems in psychic or social pathology? Or are psychoses everywhere constant but are certain types of psychotics culturally protected? For example, does Buddhism in prizing and rewarding the schizoid personality actually protect and conceal the real schizophrenic who unconsciously denies reality because his culture permits its conscious denial in ascetic practices?⁷¹

Roheim has suggested that ritual is a group catharsis for traumata produced by the socialization of the child. For instance, does a heavily ritualized life, whether that of the Pueblo Indian, the Roman Catholic or the orthodox Jew, drain off anxieties by a multiplicity of cultural behavior comparable to that devised in compulsion neuroses and thereby produce a sense of safety and

⁶⁷ H. Scudder Mekeel, "Clinic and Culture," *J. Abnormal and Soc. Psychol.*, XXX (1935), 292-300, "A Psychoanalytic Approach to Culture," *J. Soc. Philos.*, II (1937), 232-236, Review of Kardiner, *The Individual and His Society*, in *Am. Anthropol.*, XLII (1940), 526-530, "Education, Child-training, and Culture," *Am. J. Soc.*, XLVIII (1943), 676-681.

⁶⁸ "Some Anthropological Perspectives on Psychoanalysis," *Psychoanalytic Rev.*, XXIV (1937), 246-263.

⁶⁹ "Some Psychological Objectives and Techniques in Ethnography," *J. Soc. Psychol.*, VIII (1937), 285-301.

⁷⁰ *Op. cit.*, p. 250.

⁷¹ *Ibid.*, p. 261.

security? . . . How does ritual not only enact but also discharge social tensions, if at all? What light will demographic studies of populations crumbling under the impact of European colonization throw on such trends?⁷³

At least in the period prior to 1939, M. E. Opler seems to me to have produced the most impressive empirical testing of psychiatric concepts on materials from nonliterate societies. He did not stop (as have too many anthropologists!) with a general discussion of the psychoanalytic treatment of culture;⁷⁴ he went on⁷⁵ to compare the Apache shamans' therapy of functional disorders with that of modern psychiatrists. His scrutiny of Freudian theories of ambivalence in terms of his Apache data⁷⁶ has convincing workmanship of detail and received at least partial validation from field materials obtained later.⁷⁷ However, for complete acceptance of his valuable thesis it would be necessary to show that those persons whose life experience and situation necessitated a maximal repression of aggressive reactions then feared the dead more than those whose need for repression was minimal. A methodological contribution⁷⁸ demonstrates the extent to which Opler has thought through the more general implications of psychiatry for anthropology.

In a massive sequence of papers that have appeared largely since 1938, A. I. Hallowell has tenaciously applied psychiatric knowledge to his own field materials.⁷⁹ His achievement is remarkable for its sanity and for the uncommonly high order of workmanship at both psychiatric and ethnological levels.

In addition to these anthropologists for whom psychiatry has supplied a major directive of research, there are a number of others whom psychia-

⁷³ *Ibid.*, pp. 261-262.

⁷⁴ "The Psychoanalytic Treatment of Culture," *Psychoanalytic Rev.*, XXII (1935), 138-157.

⁷⁵ "Some Points of Comparison and Contrast between the Treatment of Functional Disorders by Apache Shamans and Modern Psychiatric Practice," *Am. J. Psychiatry*, XCII (1936), 1371-1387.

⁷⁶ "An Interpretation of Ambivalence of Two American Indian Tribes," *J. Soc. Psychol.*, VII (1936), 82-116.

⁷⁷ "Further Comparative Anthropological Data Bearing on the Solution of a Psychological Problem," *J. Soc. Psychol.*, IX (1938), 477-483.

⁷⁸ "Personality and Culture," *Psychiatry*, I (1938), 217-220.

⁷⁹ "Culture and Mental Disorder," *J. Abnormal and Soc. Psychol.*, XXIX (1934), 1-9, "Psychic Stresses and Cultural Patterns," *Am. J. Psychiatry*, XCIII (1936), 1291-1310, "Fear and Anxiety as Cultural and Individual Variables in a Primitive Society," *J. Abnormal and Soc. Psychol.*, XXXIII (1938), 25-47, "Shabwan," *Am. J. Orthopsychiatry*, VIII (1938), 329-340, "Sin, Sex and Sickness in Saukteaux Belief," *Brit. J. Med. Psychol.*, VIII (1939), 151-197, "Aggression in Saukteaux Society," *Psychiatry*, III (1940), 395-407, "The Rorschach Method as an Aid in the Study of Personalities in Primitive Societies," *Character and Personality*, IX (1941), 235-245.

try has touched at least casually. On the one hand, there are those who have been stimulated to write systematic descriptions of mental disorders among "primitive" peoples,⁷⁹ on the other, there are those who show psychiatric influence in at least a single publication.⁸⁰

There has been a greatly intensified collaboration of anthropology and psychiatry during the last five years. In great part this heightened psychiatric influence is indicated by enlargement of the trends which have already been delineated. A much greater number of more substantial life-history documents have been produced. Names of psychiatrists and psychiatric terms appear much more frequently in the pages of anthropological periodicals. In theory, there is increased focusing upon the role of culture in the formation of personality.⁸¹ Anthropological field work is more commonly directed to problems of psychiatric interest; the research of various anthropologists widens and deepens in psychiatric directions,⁸² and new names appear in the list.⁸³

⁷⁹ J. E. Saindon, "Mental Disorders among the James Bay Cree," *Primitive Man*, VI (1933), 1-12, D. Jenness, "An Indian Method of Teaching Hysteria," *ibid*, pp. 13-20, J. M. Cooper, "The Cree Witiko Psychosis," *ibid*, pp. 20-24, and "Mental Disease Situation in Certain Cultures," *J. Abnormal and Soc. Psychol.*, XXIX (1934), 10-17, N. S. Demerath, "Schizophrenia among Primitives," *Am. J. Psychiatry*, XCVIII (1942), 703-708.

⁸⁰ J. H. Barnett, "Personality in Primitive Society," *Character and Personality*, II (1933), 152-167, Jules Henry, "The Personality of the Kaingang Indians," *ibid*, V (1936), 113-123, M. J. Herskovits, "Freudian Mechanisms in Primitive Negro Psychology," in *Essays Presented to C. G. Seligman* (London, Kegan Paul, 1934), pp. 75-84, R. Landis, "The Personality of the Ojibwa," *Character and Personality*, VI (1937), 51-60, and "The Abnormal among the Ojibwa," *J. Abnormal and Soc. Psychol.*, XXXIII (1938), 14-33; Gertrude Toffelmier and Katherine Luomala, "Dreams and Dream Interpretation of the Diegueño Indians of Southern California," *Psychoanalytic Q.*, V (1936), 195-225, W. L. Warner, "The Society, the Individual, and His Mental Disorders," *Am. J. Psychiatry*, XCIV (1937), 275-284.

⁸¹ Ralph Linton, "Psychology and Anthropology," *J. Soc. Philos.*, V (1940), 115-127, C. Kluckhohn and O. H. Mowrer, "Culture and Personality," *Am. Anthropol.*, XLVI (Jan., 1944).

⁸² Jules and Zunia Henry, "Speech Disturbances in Pilaga Indian Children," *Am. J. Orthopsychiatry*, X (1940), 362-369, Jules Henry, "Some Cultural Determinants of Hostility in Pilaga Indian Children," *ibid*, 111-119.

⁸³ M. F. Ashley-Montagu, "Nescience, Science, and Psycho-analysis," *Psychiatry*, IV (1941), 45-60, Ann Barnard, "Patterns of Masculine Protest among the Buka," *Character and Personality*, XI (1943), 152-167, Gregory Bateson, "Some Systematic Approaches to the Study of Culture and Personality," *Character and Personality*, XI (1942), 76-82, and "Cultural Determinants of Personality," *Personality and the Behavior Disorders* (ed. J. Hunt, New York, Ronald Press, 1944), 714-736, Dorothy Eggan, "The General Problem of Hopi Adjustment," *Am. Anthropol.*, XLV (1943), 357-373, John Gillin, "Personality in Preliterate Societies," *Am. Soc. Rev.*, IV (1939), 681-702, Gillin and Victor Raimy, "Acculturation and Personality," *ibid*, V (1940), 371-380, E. S. Goldfrank, "Historic Change and Social Character," *Am. Anthropol.*, XLV (1943), 67-83, C. Kluckhohn, "Theoretical Bases for an Empirical Method of Studying the Acquisition of Culture by Individuals," *Man*, XXXIX (1939), 98-103, "Myths and Rituals: a General Theory," *Harvard Theological Rev.*, XXXV (1942), 45-79, and "Navaho Witchcraft," *Papers of the Peabody Mus. of Am. Archaeol. and Ethnol.*, Vol. XXII, No. 3.

Quantitatively, the publications of George Devereux⁸⁴ bulk larger than those of any other of the newcomers. The papers of Devereux are marked by great breadth of knowledge and by fertility of ideas; their effect in some cases is marred by apparent haste and carelessness of workmanship. In certain respects, however, Devereux is representative of developments which tend to demarcate the last five years from the earlier period under discussion. He did not learn his psychiatry merely by reading books and listening to lectures. He spent a year on the staff of the Worcester State Hospital.

An appreciable number of anthropologists have now emerged from the category of complete laymen in the field of psychiatry. They can speak with firsthand familiarity of, and to a degree use, psychiatric techniques; they are no longer restricted to "learning from" psychiatry and making crude analogical applications. Before 1939 there was, I believe, only one psychoanalyzed professional anthropologist in the United States. Today there are about a dozen. Some anthropologists have also learned to administer, and even to interpret, the Rorschach Tests.⁸⁵

The point to be underscored is that the influence of psychiatry has pro-

(1943), Weston LaBarre, "A Cultist Drug-addiction in an Indian Alcoholic," *Menninger Clinic Bull.*, V (1941), 40-46; E. M. Loeb and G. Toffelmier, "Kin Marriage and Exogamy," *J. Gen. Psychol.*, XX (1939), 181-223; D. McAllester, "Water as a Disciplinary Agent among the Crow and Blackfoot," *Am. Anthropol. n. s.* XLIII (1941), No. 4, Pt. 1, 593-604; M. K. Opler, "Psychoanalytic Techniques in Social Analysis," *J. Soc. Psychol.*, XV (1942), 91-127; J. W. M. Whiting, *Becoming a Kwoma* (New Haven, Yale Univ. Press, 1941).

⁸⁴ "Maladjustment and Social Neurosis," *Am. Soc. Rev.*, IV (1939), 844-851; "Mohave Culture and Personality," *Character and Personality*, VIII (1939), 91-109, "The Social and Cultural Implications of Incest among the Mohave Indians," *Psychoanalytic Q.*, VIII (1939), 510-533, "A Sociological Theory of Schizophrenia," *Psychoanalytic Rev.*, XXVI (1939), 315-342; "A Conceptual Scheme of Society," *Am. J. Soc.*, XLV (1940), 687-706, Review of *The Individual and His Society* (Kardiner), *Character and Personality*, VIII (1940), 253-256, "Social Negativism and Criminal Psychopathology," *J. Criminal Psychopathol.*, I (1940), 323-338, "The Mental Hygiene of the American Indian," *Mental Hygiene*, XXVI (1942), 71-84, "Motivation and Control of Crime," *J. Criminal Psychopathol.*, III (1942), 553-584; "Primitive Psychiatry, II: Funeral Suicide and the Mohave Social Structure," *Bulletin of the Hist. of Med.*, XI (1942), 522-542; "Social Structure and the Economy of Affective Bonds," *Psychoanalytic Rev.*, XXIX (1942), 303-314; Devereux, and E. M. Loeb, "Antagonistic Acculturation," *Am. Soc. Rev.*, VIII (1943), 133-147, "Some Notes on Apache Criminality," *J. Criminal Psychopathol.*, IV (1943), 424-430; see also, Karl Menninger, "An Anthropological Note on the Theory of Pre-natal Instinctual Conflict," *Inter. J. Psycho-analysis*, XX (1939).

⁸⁵ Hallowell, "The Rorschach Method as an Aid in the Study of Personalities in Primitive Societies," *Character and Personality*, IX (1941), 235-245; Hallowell, "Acculturation Processes and Personality Changes as Indicated by the Rorschach Technique," *Rorschach Research Exchange*, VI (1942), 42-50; Henry, "Rorschach Technique in Primitive Cultures," *Am. J. Orthopsychiatry*, XI (1941), 230-234; A. H. Schachtel and Jules and Zunia Henry, "Rorschach Analysis of Pilaga Indian Children," *ibid.*, XII (1942), 679-712.

ceeded beyond the stage of general talk. A period of calling attention to the relevance of psychiatric knowledge was inevitable; a period of fumbling translations between the two idioms was necessary. But this preliminary groundwork seems to have been covered to a first approximation. Active collaboration is now supplanting polite gestures. There is coöperation in research—Aginsky and Wilbur, Chapple and Lindemann⁸⁶—and particularly in field work—Erikson with Mekeel,⁸⁷ Levy with the Henrys, with Mirsky, and with Bunzel,⁸⁸ Kardiner with DuBois; Fries with Kluckhohn;⁸⁹ Alexander and Dorothea Leighton with Kluckhohn.⁹⁰ There are coöperative seminars in universities—Kardiner with Linton at Columbia, Murray with Kluckhohn at Harvard.⁹¹

The product of the Kardiner-Linton seminar is perhaps the most substantial evidence (in the generalized, theoretical field) of the fruitfulness of such cooperation.⁹² It is important to notice that, even at the written level, this was not merely a matter of an anthropologist providing raw materials for a psychiatrist to analyze. In Kardiner's book Linton wrote a theoretical introduction as well as the two ethnographic chapters. Three other publications⁹³ attest to the extent of psychiatric influence upon Linton's thinking. The Kardiner-Linton volume is undoubtedly the outstanding integration of anthropology and psychiatry to date, but since it is a case of true synthesis rather than of "the influence of anthropology upon psychiatry," it will not be discussed at length here.⁹⁴

⁸⁶ B. W. Aginsky, "The Socio-psychological Significance of Death among the Pomo Indians," *Am Imago*, I (1940), 1-11, and G. B. Wilbur, Comments (on the foregoing), *ibid.*, 12-18; E. D. Chapple and E. Lindemann, "Clinical Implications of Measurements of Interaction Rates in Psychiatric Interviews," *Applied Anthropol.*, I (1942), 1-10.

⁸⁷ E. H. Erikson, "Some Observations on Sioux Education," *J Psychol.*, VII (1937), 101-156.

⁸⁸ David M. Levy, "Sibling Rivalry Studies in Children of Primitive Groups," *Am J. Orthopsychiatry*, IX (1939), 205-215.

⁸⁹ Margaret E. Fries, "National and International Difficulties," *ibid.*, XI (1941), 562-573.

⁹⁰ (It is worth pointing out that the Drs. Leighton are not psychoanalysts.) A. and D. Leighton, "Elements of Psychotherapy in Navaho Religion," *Psychiatry*, IV (1941), 515-523, and "Some Types of Uneasiness and Fear in a Navaho Indian Community," *Am. Anthropol.*, XLIV (1942), 194-209.

⁹¹ The Sapir-Dollard seminar on the Impact of Culture on Personality (held at Yale University, 1932-33) was at least a partial precursor.

⁹² Kardiner, *The Individual and His Society* (New York, Columbia Univ Press, 1939).

⁹³ Linton, "Culture, Society, and the Individual," *J. Abnormal and Soc. Psychol.*, XXXIII (1938), 425-436, "The Effects of Culture on Mental and Emotional Processes," *Assn. for Research in Nerv. and Mental Dis., Research Publications*, XIX (1939), 293-304; "Psychology and Anthropology," *J. Soc. Philos.*, V (1940), 115-127.

⁹⁴ For sympathetic but discriminating reviews of this work by anthropologists, see Devereux, *Character and Personality*, VIII (1940), 253-256, and Mekeel, *Am. Anthropol.*, XLII (1940), 526-530.

The position of anthropology and psychiatry today, then, is roughly this: A conceptual *modus vivendi* has been established; data to test and refine this conceptual scheme are being gathered in a number of specific studies; the work of many anthropologists for whom the psychiatric type of interest is not at all central shows, nevertheless, an appreciable amount of psychiatric influence. It would be a great mistake, however, to conclude that psychiatric orientations are universally accepted at least to some degree. Lowie's *History of Ethnological Theory* (1937) gives exceedingly brief shrift to all psychiatrists, indeed a few paragraphs discussing the work of Rivers and Malinowski constitute the only systematic attention to this subject. Chapple and Coon⁹⁶ have published a general text in anthropology which does devote a number of pages to psychoses and to psychotics in society, but contains not a single mention of psychoanalysis nor of any one psychoanalyst.

The persistent resistance of anthropology is forcefully documented by two more general facts. First, by far the greater number of articles which reflect the psychiatric interests of anthropologists have been published in *non-anthropological* journals. Only within the last two or three years have there been any appreciable number of papers in the *American Anthropologist*, for example, which directly show psychiatric influence. Second, the reviews in the leading journal of a profession may be presumed to mirror major trends. The record in the *American Anthropologist* is astonishing. There are the two reviews by Kroeber which have been mentioned.⁹⁷ A psychiatrist reviewed one of Róheim's works and, as we have noted, Mekeel reviewed Kardiner.⁹⁸ That is all! The other contributions of Freud and Róheim, the books of Abraham, Reik, Rank, and many others which treat anthropological subjects unequivocally have never been noticed in the standard American journal of the anthropological profession. And, unfortunately, the conventions of field work still leave much to be desired. So far as many ethnologists are concerned, the observations of Devereux are still all too apropos:

Linton's Tanala chapter invites, however, melancholy reflections on anthropological waste. It contains all the human material which Linton could not include in his great Tanala monograph. One wonders how much material of this type, invaluable to social psychologists, is at present floating around in

⁹⁶ *Principles of Anthropology* (New York, Henry Holt, 1942)

⁹⁷ See notes 23 and 24

⁹⁸ William Morgan, Review of Róheim's *Psychoanalysis of Primitive Cultural Types*, in *Am Anthropol.*, XXXIV (1932), pp. 705-710, for Mekeel's review, see note 94.

the discarded notes and in the heads of other anthropologists, who never thought these data worthy of publication. It is hoped that Kardiner's book will help to rearrange the peculiar scale of values pervading anthropology, which induces anthropologists to devote ten pages to the making of pots, and ten lines to infancy.⁸⁸

Finally, a word must be said about a propensity which has been frequently noticeable in the last few years. Sometimes the enthusiasm for psychological explanations is not associated with a firm grasp of the essentials of psychiatric methods. Fragmentary cultural data are linked without the requisite support in case materials.⁸⁹ Anthropologists, as well as psychiatrists, are tending to indulge in highly disjunctive arguments. The starting point for psychological interpretations must surely always rest in studies of specific individuals.

There is one question which requires further exploration: Why has the development between anthropology and psychiatry been so slow, why is the permeation of psychiatric ideas so incomplete even today? I have already suggested that there might be a basic factor of temperamental selection for the two professions. In addition, there is the discomfort which laymen from whatever group frequently feel about association with psychiatrists. The fact that the psychiatrists who have dealt with anthropological matters have mostly been psychoanalysts has tended to mobilize another host of resistances which are essentially irrational in their bases and manifestations, whatever degree of rationality may be mustered for each specific criticism. In many American universities there is a pronounced *nolite me tangere* attitude with regard to psychoanalysis. Psychoanalysts are too often felt to be intrinsically rather nasty people who wallow in sex and brood over the morbidities of human life. With some greater show of rationality, psychoanalysis is denied a place in the intellectual community because of its own excessive cultism. There are other familiar objections, but the simple fact is that some of the more timorous anthropological brethren have been deterred from collaboration because of their conviction that psychoanalysis wasn't really quite respectable and that they would be damaged as to professional advancement if they sullied themselves by contact with it.

Over and above such irrational resistances, however, there are certain respects in which the psychiatrists themselves have needlessly diminished

⁸⁸ *Character and Personality*, VIII (1940), 254

⁸⁹ Jane Richardson and L. M. Hanks, Jr., "Water Discipline and Water Imagery among the Blackfoot," *Am. Anthropol.*, XLIV (1942), 331-333.

the scope of their influence. Granted that it is always unjustifiable to reject a method in its entirety (without further examination) because certain aspects of it can be shown to be incompatible with other technical evidence, or because the conclusions reached by it can be refuted on other grounds, still we must face the fact that this is a very general tendency in science. In the past, almost all psychiatrists forfeited the potential attention of a larger anthropological audience because they so flagrantly violated various canons of anthropological theory and method which were regarded by anthropologists as definitive. To greater or lesser degree, this remains true of a sizable proportion of psychiatrists who utilize anthropologic data. For a variety of reasons, psychoanalysts as a group have tended to be most familiar with the works of the classical British evolutionary anthropologists, in particular with the great compendia of Frazer. These still serve too much as inexhaustible storehouses from which psychoanalysts pilfer illustrative ornaments for this or that theory. While a gratifying number of psychiatrists have made "culture" a solid part of their conceptual repertory, many have failed to make this notion part of their habitual thinking. Although Freud himself was abundantly aware of the social dimensions of human living (the family situation and the like), it may be doubted whether he ever grasped the full import of "social heredity."

Although many good critiques have been published,¹⁰⁰ it may be useful to summarize the points on which all anthropological critics agree in substance. If psychiatrists would bear this simple list (as a minimum) in mind, they could avoid unnecessary shock to anthropological sensibilities and thus maximize the weight which psychiatrists have in anthropological quarters.

1. "Primitive" societies must not be lumped together. All anthropologists would deny such equivalence, except to the limited extent that these societies may share features in common as a result of their tendency to small size and relative simplicity in many (but not necessarily all) aspects

¹⁰⁰ Du Bois, *Psychoanalytic Rev.*, XXIV (1937), 246-263; Hallowell, "The Child, the Savage, and Human Experience" (in "Progress of Scientific Research in the Field of the Exceptional Child") *Proceedings of the Sixth Institute on the Exceptional Child, of the Child Research Clinic of the Woods School*, 1939, pp. 8-34; Kroeber, *Reviews of Totem and Taboo*, *Am. Anthropol.*, XXII (1920), 48-55, and *Am. J. Soc.*, XLV (1939), 446-451; Mead, *Character and Personality*, III (1934), 3-16; Opler, "The Psychoanalytic Treatment of Culture," *Psychoanalytic Rev.*, XXII (1935), 138-157.

of their cultural inventory, and as a consequence of their all being outside a written language tradition.¹⁰¹

2. Psychiatrists must cease to equate "primitive" with "childlike" or "archaic" or, in any unqualified sense, with "simple" (as opposed to "complex").¹⁰²

3. The anecdotal approach is worthless. Ethnological data must be used with a fair regard for their context, both historical¹⁰³ and situational.

4. Cultures must be regarded as wholes, having organization as well as content. Data must not be too cavalierly torn from their configurational context (any more than from their historical or situational contexts).

5. The premises of theoretical arguments must be congruent with anthropological theorems (or cause must be shown for rejecting or disregarding the latter). That is, psychiatrists must not tacitly or uncritically accept a conceptual scheme (for example, that of "evolutionary" anthropology) which professional opinion unanimously regards as unacceptable (in the traditional sense, at least). This means further that for psychiatrists to use such hypotheses as that of the "racial unconscious," for which, anthropologists would argue, there never was evidence admissible in the court of science, is inevitably to wave a red flag at the anthropological bull.

6. At least before indulging in far-flung theories, psychiatrists must acquire a fuller control of the relevant anthropological literature than they have commonly shown in the past. There must be less uncritical use of data, as well as less snatching of data out of context.

If psychiatrists will respect these six points and their implications, anthropologists will reciprocate with an enthusiasm for psychiatry less sharply restricted to a small though growing intellectual clique within the anthropological profession.

Let us now, in conclusion, summarize the gains which this clique may claim to have attained from their study of psychiatry.

1. In the techniques of field research, a completely new conception of

¹⁰¹ Cf. Mead, *op cit* "The significance of primitive societies for the study of personality lies not in the similarities between them but in their differences."

¹⁰² There might be a gain to clarity in communication, if the multivalued word "primitive" were at least temporarily stricken from our professional vocabularies. "Nonliterate" is unequivocal and objective. "Preliterate" must be strictly avoided as question-begging, specifically as implying acceptance of the evolutionary schema.

¹⁰³ Cf. Mead, *op cit*, p. 13. "Each culture must be studied against the background of the general area to which it belongs", that is, diffusion must not be ignored.

the number and character of informants needed has come as much from psychiatry (especially through Sapir)¹⁰⁴ as from sampling theory in statistics. Many anthropologists now feel an obligation to provide their readers with much more information and controls on this subject¹⁰⁵

The need for more systematic attention to interpersonal relations between ethnographer, informants, and interpreters has gained some recognition.¹⁰⁶ While anthropologists are still notably inarticulate (at least in print) about their interview methods and their relationships with the "natives" generally, still evidence is not lacking that the more sophisticated have at any rate begun seriously to consider such matters—which were formerly handled by very crude rules of thumb. Anthropologists have learned much from psychiatry about the technique of the interview, including how to get anxiety-protected material. Although the precise parallels to the transference situation have yet to receive an extended published discussion, there are hints that thought is proceeding along these lines.¹⁰⁷

Under the impact of psychiatry, anthropology has come to recognize the incompleteness of the question and answer method. The need for passive interviews, for controlled observations, even for simple experiments, for personal documents, dreams, phantasies of individuals, and other informal materials is now seen by a large number of field workers.

The content of field research—that is, the topics upon which the investigator must report if he is to be considered professionally respectable—has been much enlarged and sharply revised.¹⁰⁸ Though there is still great room for improvement in this direction, even those changes which are generally accepted are considerable.

In general, greater attention should be paid to intensive as opposed to extensive procedures.¹⁰⁹

2. In theoretical anthropology new topics have been added. Psychiatry is primarily responsible for the granting of full recognition to interpretative studies of such subjects as the following: "the individual in culture";

¹⁰⁴ See notes 52-59

¹⁰⁵ Kluckhohn, "Theoretical Bases for an Empirical Method of Studying the Acquisition of Culture by Individuals," *Man*, XXXIX (1939), 98-103

¹⁰⁶ Du Bois, "Some Psychological Objectives and Techniques in Ethnography," *J. Soc. Psychol.*, VIII (1937), 246-263.

¹⁰⁷ An obvious limitation upon the full use of psychiatric techniques in interviews is the lamentable fact that only a trifling number of anthropological field workers have an adequate command of the native idiom

¹⁰⁸ Mead, "More Comprehensive Field Methods," *Am. Anthropol.*, XXXV (1933), 1-15

¹⁰⁹ H. D. Lasswell, *World Politics and Personal Insecurity* (New York, McGraw Hill, 1935), pp. 210-211.

"culture and personality"; child socialization, transmission of culture through child-training; the "abnormal" or "deviant" person; life histories; culture and motivation, the origin of culture (in a new sense), a new attack on configurational analysis ("To what degree can we understand the plot or theme of a culture by reference to the recurrent traumatic situations to which the child is subjected in the family situations?"),¹¹⁰ a different approach to "the instinct problem";¹¹¹ psychosomatic problems: The relationship of disease pictures to culturally determined forms of character structure.¹¹²

And there are new conceptual tools. There is wide variation in the extent to which even psychiatrically oriented anthropologists accept and utilize psychiatric concepts. But it may be said that, save among the die-hard conservatives, such notions as "ambivalence," "identification," and "latent content" are now part of the standard conceptual currency.

Concepts derived from psychiatry have proved of peculiar value in the theoretical interpretations which anthropologists must make of such phenomena as family behavior,¹¹³ religion,¹¹⁴ clowns and formalized joking,¹¹⁵ suicide,¹¹⁶ narcotics, and alcoholism.¹¹⁷

In conclusion, it may be noted that anthropologists have altered many of their postulates. The whole thinking about the individual informant as a cultural specimen has been sharply refashioned.¹¹⁸ The false antimony of "the individual *vs.* society" is gradually being abandoned. Assumptions as to the relative proportions of irrational, nonrational, and rational elements in human behavior have been revised; although this last trend was independently forced upon anthropology by its own materials, the trend was given increased momentum by pressure from psychiatry.

¹¹⁰ Mead, "Review of 'The Riddle of the Sphinx' by G. Róheim," *Character and Personality*, IV (1935), 86.

¹¹¹ Mead, "Anthropological Data on the Problem of Instinct," *Psychosomatic Med.*, IV (1942), 396, 397.

¹¹² Mead, "Character Formation in Two South Seas Societies," *Am. Neurol. Assn. Transactions*, 66th Annual Meeting, June, 1940, pp. 99-103. Gregory Bateson and Margaret Mead, *Balinese Character*.

¹¹³ Kardiner, *op. cit.*

¹¹⁴ Kluckhohn, "Myths and Rituals," *Harvard Theol. Rev.*, XXXV (1942), 45-79.

¹¹⁵ J. J. Honigman, "An Interpretation of the Social-psychological Functions of the Ritual Clown," *Character and Personality*, X (1942), 220-226.

¹¹⁶ B. W. Aginsky, "The Socio-psychological Significance of Death among the Pomo Indians," *Am. Imago*, I (1940), 1-11.

¹¹⁷ Kluckhohn, *Navaho Witchcraft*.

¹¹⁸ Sapir, "Cultural Anthropology and Psychiatry," *J. Abnormal and Soc. Psychol.*, XXVII (1932), 229-242, "The Emergence of the Concept of Personality in a Study of Cultures," *J. Soc. Psychol.*, V (1934), 408-415, "Personality," in *Encyclopaedia of the Social Sciences*, XII, 85-87.

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